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ABSTRACT

These guidelines were developed to assist Connecticut school personnel to strengthen collaborative efforts among families, educators, and health professionals to provide effective programs for students with special health care needs. The guidelines assist in identifying appropriate services and service providers and in planning the support services necessary to ensure the safety and well-being of all students during participation in school activities. They provide a framework for the development of appropriate policies and procedures, and are based on laws and regulations that apply to education, medicine, nursing, and other health disciplines. The guidelines begin with an overview of issues related to children with special health care needs in educational settings, followed by a consideration of a philosophy and conceptual framework, legal issues from an educational perspective and a clinical perspective, policy and procedure development, the decision-making process, personnel, the entry/re-entry process, program modifications, funding issues, infection control, a self-evaluation tool, and specialized health care activities. Appendices provide statements of standards and licensure requirements; sample forms; definitions; model policies; article reprints; and a list of governmental and nongovernmental resources, primarily in Connecticut. (Approximately 120 references) (JDD)

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Serving Students With Special Health Care Needs

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FOREWORD

More than ever before, local and regional school districts are challenged by students who have special health care needs. These needs must be met so that the students can benefit from their educational programs. In keeping with societal goals and federal and state mandates, children with chronic health conditions, both physical and psychological in nature, are attending school, not only in special educational settings, but increasingly in regular educational classrooms. In order to meet the challenge, school districts must provide the quality and range of services, as well as environmental safeguards, necessary for students to maintain their health during the school day.

To be effective, educational programs should incorporate the health services and program adaptations necessary to minimize the effects of a student's health condition on educational progress, to prevent unnecessary complications from disease or medical treatment, and to diminish absenteeism and other interruptions in a student's education. Such services and adaptations must be provided in a developmentally appropriate and least-restrictive environment in order to benefit both affected students and their peers. Furthermore, close collaboration among families, educators and health professionals is critical if schools are to succeed in providing effective programs for those students with special health care needs.

The Connecticut State Department of Education is pleased to offer these guidelines to assist school personnel to strengthen such collaborative efforts. We must understand the special needs of students with chronic health conditions and provide educational programs that maximize a student's physical, cognitive and psychosocial potential. Despite complex legal and financial issues related to serving this student population, schools and communities can work in concert to significantly enhance the life opportunities of children with special health care needs.

These guidelines were produced through the collaborative efforts and combined expertise of families, educators and school and community health professionals. While they take into account the individual characteristics of Connecticut school districts and school health service programs, they are also based on current professional literature. It is hoped that local and regional school districts will build upon these guidelines to develop, enhance and promote safe and appropriate educational opportunities for students with special health care needs. Furthermore, feedback is welcome as we strive to work together to improve the life opportunities of students with special health care needs.

Marilyn A. Campbell

Marilyn A. Campbell
Acting Commissioner of Education

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OVERVIEW

The purpose of this document is to assist schools, regional educational service centers or other settings where educational services are being provided to students with special health care needs in Connecticut to identify appropriate services and service providers for students with special health care needs in the school setting and to plan the support services necessary to ensure the safety and well-being of all students during participation in school activities. The guidelines are intended to provide a framework for the development of appropriate policies and procedures to meet the diverse health care needs of students in school settings today. Further, they are based on the laws and regulations that apply to education and on the laws, regulations, licensures and professional standards of practice that currently apply to the practice of medicine, nursing and other health disciplines in Connecticut.

Definition

Within this document, the term "student" refers to all children, age 0 to 21 years, who are entering or are in educational programs. The term "student with special health care needs" refers to:

> *one who may require technology, health services and/or some other form of health-related support services or program modifications in order to access an appropriate educational program.*

The definition is broad in order to incorporate the entire range of students with special health care needs, whether physiological or psychological in nature, on a continuum from mild to severe and with actual or potential health service needs that must be addressed within school environments. While there is considerable emphasis in this document on those students with more severe physical health impairments, the philosophy and general guidelines are intended to apply to the entire spectrum of students with health service needs in the educational setting. Students with special health care needs that are psychological in nature include those who have mental, emotional and behavioral problems and require medication and/or special services, supports or programs to address those problems.

Whether a specific student's health impairment and health service needs impact on his/her eligibility for special education cannot be determined in general guidelines. Therefore, it is **not** the intent of this document to identify who may or may not be handicapped under either Section 504 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (IDEA), formerly the Education of the Handicapped Act, or Sections 10-76a to 10-76h, inclusive, of the Connecticut General Statutes and Regulations. Related legal issues will be addressed in the section *Legal Issues — Educational.*

Background

The committee to develop guidelines for students with special health care needs was formed in response to the increasing numbers of children with acute, long-term and chronic health problems who attend school in Connecticut. Across the nation, children with complex health impairments, and equally complex health service needs, not only live longer than in the past, but are able to live at home, attend school and participate in

their communities. Scientific and technological advances in the health care field have greatly enhanced the life opportunities of children with physical health impairments. It is no longer uncommon for children requiring special health care services and high technology procedures to be discharged home from the hospital, or not to be treated in the hospital at all, and to attend school. Some of these children are even dependent on external equipment and support for survival. Similarly, changes in the treatment of children with emotional and mental illness have resulted in fewer hospitalizations and increased out-patient treatment while the child is home and attending school. Children with special health care needs at the milder end of the spectrum may also require services or adaptations in school in order to minimize the negative effects of their conditions or of the treatments prescribed to control them.

Statistics

Estimates of the population of children who experience some form of chronic health condition before reaching the age of 18 years range up to 40 percent of all American children, depending on the range of health conditions addressed (Thomas, 1987). Included in this group are the 10 to 20 percent who experience long-term illness or chronic disease and the two to four percent, often referred to as "medically fragile," "medically dependent" or "high technology" children, who experience severe disease on a regular basis (Perrin & MacLean, 1988). Additionally, estimates of the number of children in the United States eligible for special education and related services under the category "other health impaired" vary from one to ten million (Hobbs, et al., 1984), while the actual numbers served are low (54,565 for all ages in 1983-84 and 52,658 for all ages in 1988). Studies further suggest that from 8 to 12 percent of all children and adolescents have sufficient emotional and behavioral problems to warrant intervention. An estimated three to five percent of these have very serious emotional problems, and there are indications that the number is growing (Knitzer et al., 1990). In Connecticut, recent prevalence studies regarding mental health problems in 6- to 12-year-olds identified that 38.6 percent of children age 6 through 12 years in an urban area, and 32 percent of those in a rural area, are at risk of emotional disturbance, and that 11.7 percent of 6- to 12-year-old children in the urban area are at risk of child psychiatric disorders. Furthermore, data currently available indicate that Connecticut does not appear to be identifying and providing treatment for all children and youth in need of mental health services (Connecticut Department of Children and Youth Services, 1989).

Diversity

The population of children and youth with special health care needs is a diverse one, since their conditions vary widely according to numerous factors. These factors of diversity include, but are not limited to:

- specific diagnosis;
- age of onset;
- the natural course, duration and severity of disease processes or extent of disability;
- chronological age compared to the child's developmental stage;
- treatment regimens;
- family circumstances;
- impact on the child and family (functional, psychosocial, cultural and financial);
- visibility of the condition; and
- long-term outcomes (cure, stability, or deterioration).

While the specific diagnoses of students with special health care needs do, indeed, vary widely, they can be categorized by general type of disease or condition. These general categories, with examples of each type, are listed below. The list is not inclusive.

- **Chronic Disease**
  - Asthma
  - Cancer
  - Cystic Fibrosis
  - Diabetes
  - Seasonal respiratory allergies
  - Sickle cell anemia
- **Chronic Infectious Disease**
  - Hepatitis B infection
  - Human Immunodeficiency Virus (HIV) infection
  - Mononucleosis
- **Physical Condition**
  - Congenital heart defect
  - Spina bifida
- **Psychological Condition**
  - Childhood psychosis
  - Chronic depression
  - Conduct disorder
- **Acquired Disability**
  - Traumatic brain injury
  - Lead poisoning
  - Drug addiction
  - Broken leg
- **Severe Acute Illness**
  - (which may require complex medical care over several weeks or months)
  - Nephritis (kidney infection)
  - Osteomyelitis (bone infection)
  - Pneumonia (lung infection)

The diversity of children and youth with special health care needs is also complicated because physical and psychological impairments are closely interrelated: aberrant behavior may be symptomatic of an underlying physical condition; psychological problems may be manifested in physical illness; and because children often experience difficulties in coping with their health conditions, they may develop related emotional problems which require intervention. These variables are further confounded by the fact that mild physiologic disease in some children may result in significant educational handicap, while moderate or severe disease in others may result in little or no educational handicap (Perrin, et al., 1984).

Common problems and needs

Despite the diversity of this population, it is now well recognized in the health and education literature that children and youth with special health care needs share similar problems. In the realm of education, it is well documented that students with moderate to severe health impairments show distinct behavior changes on a continuous or episodic basis (Walker, 1986). The incidence of absenteeism, underachievement and social adjustment problems is also disproportionately higher among children with chronic illness than their healthy peers (Weitzman, 1984; Weitzman, Walker and Gortmaker, 1986; and Satterwhite, 1978). Peer and adult rejection, isolation and disabling responses by adults who come in contact with affected students, such as overprotection

and underestimation, are common problems. While the majority of students with chronic illness have average or above-average learning ability (Walker, 1986; and Perrin & Hobbs, 1985), those with more severe impairments have frequently been unable to attend school in the regular classroom due to lack of sufficient health services in the educational setting, often related to funding. Additionally, students with less severe or less apparent health impairments who have been in regular school programs, including those with behavioral and adjustment difficulties, often have not had the support services, program modifications, advocacy or professional understanding (Chester & Barberin, 1986) necessary to promote optimal development, self-esteem and academic achievement consistent with their ability, or to maintain an optimal level of wellness while in school.

It is also documented in the literature that students with health impairments have needs similar to those of students without such impairments. For these students, access to education requires:

- assessment and periodic reassessment of the child's health status and level of functioning on a daily or intermittent basis in order to determine what special services or program modifications he/she may need;
- policies which support close collaboration with families;
- safe professional practice;
- appropriate instructional programs;
- related services necessary to ensure successful functioning in educational settings;
- enhanced communication and collaboration with health and social service providers in the community;
- education of school personnel; and
- smooth interdisciplinary teamwork.

Finally, children with health impairments share the following common needs to:

- interact with healthy children;
- identify and capitalize on their strengths; and
- mature to be positive, productive, content and socially responsible adults with the minimum disability possible.

Meeting the challenge

Advances in science and health care technology, in conjunction with society's increased commitment to promoting optimal learning and development for all children, have certainly increased the opportunities for students with special health care needs to better realize their own potential. However, these advances also bring with them substantial challenges for families, schools, health care providers, communities and society as a whole. In order to meet these challenges in an effective, efficient and safe manner, it is crucial that experts in education, health, social services, law, financing and municipal services collaborate with families and communities in identifying and promoting those practices and programs which will enhance the quality of these students' lives. Clearly, a crucial step in meeting the special health care needs of students is the collaborative development, implementation and evaluation of standards and guidelines to ensure the provision of safe and appropriate education and support services in school settings.

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Additional resources can be found in the Bibliography.

A PHILOSOPHY AND CONCEPTUAL FRAMEWORK

The following philosophy and conceptual framework are based on the premise that a student's health impairment and/or the medical treatments used to ameliorate the effects of that impairment can significantly impact on the student's ability to perform and derive benefit from his/her educational program. Health impairments impact on an individual student's ability to learn and profit from educational experiences **unevenly and at varying times**. Due to the dynamic nature of a student's health status, special health care needs may be present:

- daily;
- only once or twice a week;
- periodically;
- seasonally;
- on an emergency basis only; or
- for a single protracted episode.

Additionally, such special needs may change in type or extent at any time, either abruptly, as in a crisis, or more gradually, as with maturation or chronic disease progression.

In order for a student with special health care needs of any age to access and derive benefit from an appropriate program, whether in special or regular education, preschool or adult transition, it is essential for school personnel to collaborate and coordinate services with families, health care professionals and other community service providers. Children with special health care needs must attend school in an environment that is safe, that promotes maintenance of an optimal health status, and that fosters the achievement of normal developmental tasks, personal satisfaction, optimism and independence. School personnel must not only understand and address the special health care needs of individual students, but must also understand the **priorities of their families** and support the individual student and family to achieve their goals. Therefore, if school programs and support services are to meet the varied needs of students with special health care needs, they must be:

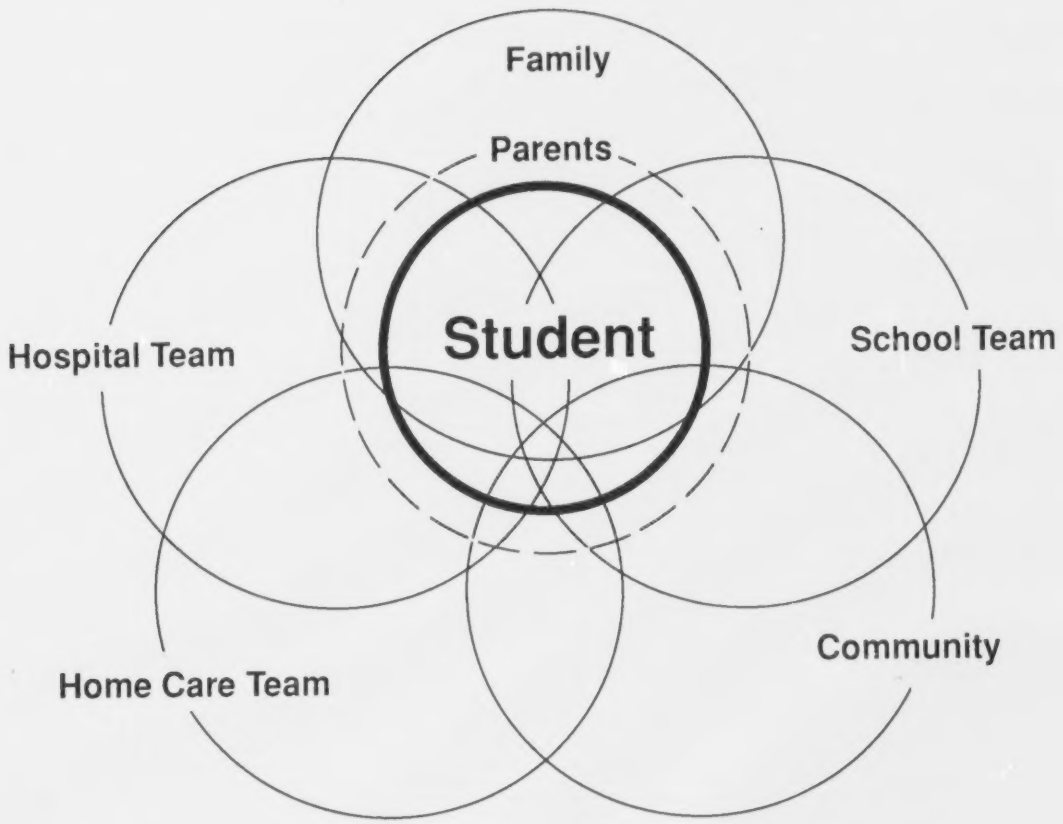
- child focused;
- family centered;
- developmentally appropriate;
- continuous and flexible;
- coordinated with health services, other community services and family;
- provided in a safe and least restrictive environment;
- high quality; and
- documented.

In the following conceptual framework, the student, who is one member of a family unit, is represented in the center as the focus of all services. As the student's health status changes, so may the emphasis of his/her service needs, at times requiring actual movement from one system to another (for example, from school to home or home to hospital) and at other times requiring changes in his/her care or program within the same setting. To whatever degree possible, the student's parent is his/her main advocate

and "case manager," although the dotted line that represents the parent in this role (see diagram on page 9) signifies the parent's loss of normal control. Infrequently or regularly, depending on the nature of the physiological or psychological health impairment, the parent and student may need to negotiate and coordinate activities with several major societal systems (e.g., schools, hospitals, community resources such as primary health care providers, day care services, mental health centers and related support organizations, home health care, and public or private funding sources) as well as with their own nuclear and extended family members and the parent's workplace. The additional stresses experienced by the student and family in this process are enormous. It is imperative, therefore, that the school system collaborate with the family to identify an appropriate member of the school team to act as the family's **"school liaison"** to facilitate timely communications and coordinate services both within the school setting and between school and home. The designated school liaison should be consistent over time and should advocate for the student and family in the education setting.

In the conceptual framework presented on the next page, each system overlaps to some degree with every other system providing services for the student in collaboration with the parent and family. The overlapping lines, focused on the child and centered with the family, represent the continuous and effective communications and coordination of services that must exist both between systems and with parents if those services are indeed going to enhance and maximize benefits to the student. School personnel must develop educational programs that are flexible and appropriate for the student at any given time. They must also develop strategies to collaborate with other professional teams across systems to facilitate safe environments, appropriate educational programs and smooth transitions for students.

A Conceptual Framework for Child-Focused, Family-Centered Coordinated Services



School personnel need to be knowledgeable about the variety of federal and state statutes and regulations which set minimum requirements for the provision of educational and related services to disabled children who may also have chronic medical conditions or are dependent on medical technology. The Individuals with Disabilities Education Act (IDEA) of 1990, an update and retitling of the 1974 Education of All Handicapped Children Act (EHA), and Section 504 of the Rehabilitation Act of 1973 define the parameters of a school district's responsibility to provide services to disabled children. While the two statutes are similar in that populations of disabled children are afforded due process protections to ensure the delivery of a free, appropriate public education, they are dissimilar enough that it is critically important for districts to recognize the differences and the varying responsibilities of providing services under each one.

IDEA Issues

Under IDEA, a child's eligibility for special education and related services is contingent upon meeting the criteria for eligibility; that is, the child must be identified as having one, or a combination of, the disabling conditions listed in IDEA and that disability must adversely affect the child's educational performance. IDEA states that "children with disabilities" means children:

(a) with mental retardation, hearing impairments, including deafness, speech or language impairments, visual impairments, including blindness, serious emotional disturbance, orthopedic impairments, autism, traumatic brain injury, other health impairments, or specific learning disabilities; and

(b) who, by reason thereof, need special education and related services {20 USC 1401 (a)(1)}.

If a student with a health-related condition does not have any other disability as listed above, the inquiry should focus on whether the student may be eligible for special education as "other health impaired" (OHI). OHI is defined as:

> limited strength, vitality or alertness, due to chronic or acute health problems such as heart condition, tuberculosis, rheumatic fever, nephritis, asthma, sickle cell anemia, hemophilia, epilepsy, lead poisoning, leukemia or diabetes, **which adversely affects educational performance** {34 C.F.R. 300.5(b)(7)(ii) (emphasis added)}.

In Connecticut it is the responsibility of a legally constituted Planning and Placement Team (PPT) to evaluate a student's eligibility for special education and related services. In designing an appropriate evaluation, the student must be assessed in all areas related

to the suspected disability, including where appropriate health, vision, social and emotional status, general intelligence, academic performance, communicative status and motor abilities {34 C.F.R. 300.532(f)}.[1] Medical services may also be provided for diagnostic or evaluation purposes; see 34 C.F.R. 300.13(a).

A key component of this multidisciplinary evaluation for a student with a health-related condition is a health assessment to be conducted by the school nurse. Based on this assessment, the school nurse identifies those health issues that are relevant to the student's educational progress and recommends services or program modifications that the student requires. If a student with health-related disabilities is determined eligible for special education and related services under IDEA, an Individualized Health Care Plan (IHCP) with specific behavioral objectives, interventions and evaluation criteria should be initiated by the school nurse at the direction of the PPT, finalized by the PPT and incorporated into the student's individualized education plan (IEP).

The IEP is developed by the PPT **after** the child is found to be eligible for special education and related services. "Special education" is defined as specially designed instruction, at no cost to the parent, to meet the unique needs of a disabled child, including instruction conducted in the classroom, in the home, in hospitals and institutions, and in other settings and instruction in physical education {20 USC 1402(a)(17)}. Related services are defined as:

> . . . transportation and such developmental, corrective, and other supportive services as are required to assist a disabled child to benefit from special education and includes speech pathology and audiology, psychological services, physical and occupational therapy, recreation, early identification and assessment of disabilities in children, counseling services and medical services for diagnostic or evaluation purposes. The term also includes school health services, social work services in school and parent counseling and training {34 C.F.R. 300.13(a)}.[2]

An IEP must include a statement of the child's present levels of educational performance, a statement of annual goals, including short-term instructional objectives, a statement of the specific special education and related services to be provided to the child and the extent to which the child will be able to participate in regular educational programs, the projected dates for initiation of services and the anticipated duration of the services and appropriate objective criteria and evaluation procedures and schedules for determining, on at least an annual basis, whether the short-term instructional objectives are being achieved. Additionally, transition services need to be addressed in the IEP including statements regarding agency responsibility or linkages (34 C.F.R. 300.346).[3]

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[1]This section is not intended to provide a full explanation of procedural safeguards under IDEA. If further information is required, please contact the Special Education Resource Center for a statement of parental rights.

[2]Under the proposed amendments to the IDEA regulations, which reflect the statutory changes to IDEA, 34 C.F.R. 300.13(a) would include therapeutic recreation and rehabilitation counseling in the list of related services and remove the "in school" limitation currently imposed on social work services.

[3]The inclusion of transition services as an IEP component is contained in the proposed amendments to the IDEA regulations.

The scope of related services to be provided to a medically fragile student is an issue which has been the subject of several important court cases. The main controversy involves whether or not a district is being asked to provide a related service, i.e., a school health service, or is it being asked to provide a medical service which it is not required to provide under IDEA. Additionally, courts have recently ruled on a school district's responsibility to pay for the entire costs of placements made to address a child's emotional and psychiatric needs (see Appendix K).

Once an IEP is fully developed, the PPT must then decide what is the most appropriate setting in the least restrictive environment (LRE) in which the child may receive the IEP. LRE has several factors which require examination. 34 C.F.R. 300.550 states:

> (b) Each public agency shall insure:
>
> (1) that to the maximum extent appropriate, disabled children, including children in public or private institutions or other care facilities, are educated with children who are not disabled; and
> (2) that special classes, separate schooling or other removal of disabled children from the regular educational environment occurs only when the nature or severity of the disability is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily.

Each school district must offer a continuum of alternative placements from least restrictive to most restrictive which includes instruction conducted in regular classes, special classes, special schools, home instruction, and instruction in hospitals and institutions, and must provide supplementary services to be provided in conjunction with regular class placement (34 C.F.R. 300.551). Under the provisions of 34 C.F.R. 300.552, a school district, in determining a child's educational placement, must insure, among other things, that the placement is based on the IEP and is as close as possible to the child's home. Unless the IEP requires some other arrangement, the child must be educated in the school which he or she would attend if not disabled.

For a medically fragile child, placement in the LRE becomes problematic where there is the possibility of increasing the medical risk to the child as the child is moved from home to school program, etc. In determining the placement option for a particular student, the PPT will need to consider such things as medical recommendations (including the student's physician, the school medical advisor, the school nurse), the parents' desires for placement, the student's desire for placement and the PPT recommendations. While the factors to be considered in determining placement options for medically complex students may require nursing/medical expertise, the general procedure for placement must be followed. A complete IEP is developed, and placement options are then discussed starting with the appropriateness of placing the child in a regular education class and why this is or is not feasible. Whether a support service is a related service, i.e., school health (nursing) services, is a critical issue in determining placement options. If the services required by the student are considered medical rather than a related service and, therefore, not the responsibility of the school district, the student's placement options may become more restrictive.

When there is a disagreement over the evaluation, identification, program or placement of a child requiring special education, either the school district or the parent may initiate a due process hearing. In Connecticut, the parties may request a mediation prior to the hearing: a neutral state mediator is appointed to assist the parties in negotiating an agreement. If the mediation terminates unsuccessfully, or if the parties choose to go directly to a hearing, the state appoints an impartial hearing officer to hear the case. Evidence is presented, both oral and written, witnesses may be cross-examined and written legal briefs may be filed. Ultimately, the hearing officer rules on the issues after assessing the facts presented and applying appropriate legal standards. If either party disagrees with the decision of the hearing officer, an appeal may be taken to either Federal or State court.

Additionally, if a parent believes that a procedural violation has occurred, i.e., the IEP is not being implemented, records are not released in a timely fashion, etc., the parent may file a complaint with the complaint officer of the Department of Education.

Section 504 Issues

If after the Planning and Placement team evaluates and finds that a health-impaired student's disability does not adversely impact educational performance and that student is therefore not eligible for services under IDEA, the student may be considered handicapped for purposes of Sec. 504 of the Rehabilitation Act and, therefore, entitled to its protections.

Section 504 is a basic civil rights statute which prohibits discrimination on the basis of handicap by recipients of federal funds. Public school districts are recipients of Federal funds. Sec. 504 specifically provides:

> . . . No qualified handicapped individual shall, soley by reason of his handicap, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity which receives or benefits from Federal financial assistance {34 C.F.R. 104.4(a)}.

A person who is considered handicapped for purposes of Sec. 504 protections is any person who "(i) has a physical or mental impairment, which substantially limits one or more major life activities, (ii) has a record of such an impairment, or (iii) is regarded as having such an impairment" {34 C.F.R. 104.3(j)}.

A physical or mental impairment is defined as any "physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive; digestive, genito-urinary; hematic and lymphatic; skin; and endocrine or any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities" {34 C.F.R. 104.3(j)(2)(i)}. And, a "major life activity" means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working" {34 C.F.R. 104.3(j)(2)(ii)}.

Qualification as a handicapped person under Sec. 504 is much broader than the eligibility requirement under IDEA; in fact, it is conceivable, particularly with students who are medically dependent, that if they are not eligible for special education services under IDEA, they are most likely qualified under Sec. 504. The critical difference is the impact on educational performance: this specific criteria is not found in Sec. 504. A student may have a disability which qualifies him as handicapped under Sec. 504, but that disability does not adversely affect educational performance. Stated another way: eligibility under IDEA requires the identification of a disabling condition recognized under IDEA and that disability must result in the need for special education. Section 504 is much broader and focuses on "protection" against discrimination as opposed to eligibility for special education. While Sec. 504 requires that the condition "substantially limit a major life activity", it need not necessarily adversely affect the student's educational performance.[4]

For example, a student with cystic fibrosis who is able to progress academically with his peers requires respiratory therapy (postural drainage, percussion and inhalation therapy) once a day in order to access his regular school program. Whether or not he is eligible for special education under IDEA, he clearly is handicapped under Sec. 504 criteria and the school district must provide the related service in a safe and timely manner and by a qualified person. Other examples of disabilities which, if they substantially limit a major life activity, may qualify a student as handicapped under Section 504, but not necessarily eligible for special education under IDEA are: communicable diseases: AIDS, ARC, asymptomatic carriers of the AIDS virus, TB; temporary handicapping conditions; ADD; behavior disorders; chronic asthma and severe allergies; physical handicaps such as spina bifida, hemophilia, and diabetes.[5] Also, it is important to note that any of these conditions may be severe enough to affect educational performance and therefore the student may be eligible for services under IDEA.[6]

The district has a responsibility to follow the procedural requirements of Sec. 504 to afford the student a free, appropriate education, which includes procedures for preplacement evaluation and evaluation, placement procedures and procedural safeguards. Additionally, Sec. 504 addresses placement in the LRE for both academic non-academic settings.

Districts may meet some of the Sec. 504 obligations by implementing an IEP according to the IDEA procedures, or by complying with the procedural safeguards of IDEA. At a minimum, districts must "establish and implement, with respect to actions regarding the identification, evaluation, or educational placement of persons, who, because of handicap, need or are believed to need special instruction or related services, a system of procedural safeguards that includes notice, an opportunity for the parents or guardian of the person to examine relevant records, an impartial hearing with opportunity for participation by the person's parent or guardian and representation by counsel, and a review procedure" (34 C.F.R. 104.36).

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[4]"Student Access - Sec. 504 of the Rehabilitation Act of 1973", Summer, 1990, Oregon Department of Education, page 3.

[5]Ibid.

[6]Ibid.

A review of Letters of Finding entered by the Office of Civil Rights which enforces Sec. 504 finds that districts routinely fail to meet the minimum procedural requirements of Sec. 504. For example, if a child's disability does not impact educational performance, a district may mistakenly refuse to evaluate to determine qualification as a handicapped person for purposes of Sec. 504. Districts must ensure that **all** handicapped students, whether or not they are eligible for services under IDEA, are appropriately evaluated for purposes of Sec. 504.

For students with health concerns, qualification under Sec. 504 guarantees them certain rights in addition to those discussed earlier: the right to participate in all activities and service areas, including extracurricular activities, and to have reasonable accommodation and support available for their special needs. Under Sec. 504, an "appropriate education" is the provision of regular or special education and related aids and services that are designed to meet the individual educational needs of handicapped persons as adequately as the needs of nonhandicapped persons are met. Related services, including health services, can be provided to a student who is not eligible for special education.

Sec. 504 recognizes two very important possibilities: (1) a population of handicapped persons who are not eligible for special education under IDEA who are still in need of protection against discrimination because of a Sec. 504 handicap; and (2) there is an obligation imposed on recipients (public schools) to provide services (evaluations, regular education, reasonable accommodations, related services and related aids) regardless of eligibility for special education under IDEA[7]. A district may be required to provide related services or other aid under Sec. 504 in the absence of any provision of special education. Consequently, health or other support services will be provided by, and funded through, the regular education options offered by school districts.

Included as Appendix K to this manual is a paper entitled "Legal Issues of Educating Children with Medical Needs" prepared by attorney Kristen Reasoner Apgar, director, Bureau of Special Education Appeals, Massachusetts Department of Education. Attorney Apgar discusses relevant court cases on eligibility under IDEA and Sec. 504, the scope of related services, LRE issues, the availability of accessing third-party resources to provide for school-based nursing services and school district liability. In addition to an understanding of the basic requirements under IDEA and Sec. 504, district personnel should familiarize themselves with the trends appearing in the courts.

[7]Liaison Bulletin, NASDE, Sec. 504 of the Rehabilitation Act of 1973; Old Problems and Emerging Issues of Public Schools, October, 1991, page 6.

Just as there are complex educational/legal issues related to the education of students with special health care needs, there are equally complex clinical/legal issues regarding the provision of safe and appropriate health care services for special needs students when they participate in school programs. In order to understand the complexity of these issues, it is necessary to review the laws, regulations and professional standards of practice that govern the practice of health care professionals in this state. While the emphasis in this section will be on the laws, regulations and standards that apply to the practice of medicine and nursing in Connecticut, it is important to recognize that other health care professionals require licensure for entry into practice in this state. These include occupational and physical therapists, speech-language pathologists and clinical psychologists.

Regulations

The Department of Health Services has regulatory responsibility for licensure of all health care professionals. In order to fulfill its obligation to protect the health, safety and welfare of its citizens, the state legislature delegates the function of regulating the practice of certain health professions to respective Boards of Examiners and the Department of Health Services. School health professionals whose practices are regulated by a respective Board of Examiners include physicians, nurses, physical therapists and clinical psychologists. (The practice of other school health professionals, including occupational therapists, speech language pathologists and independent social workers are regulated through licensure by the Department of Health Services.) For example, the Board of Medical Examiners regulates medical practice in Connecticut and the Board of Examiners for Nursing regulates nursing practice in the state. Statutes enacted by the legislature grant specific power and authority to these boards to regulate professional practice (regardless of the setting) and to monitor professional activities. The Board of Examiners for Nursing in Connecticut has the power and authority to determine, based on the Nurse Practice Act, the scope of practice of the professional registered nurse (RN), as well as the scope of practice of the licensed practical nurse (LPN). The board is responsible for determining what professional nursing functions can be delegated to the LPN and what nursing functions or tasks can be delegated to unlicensed individuals. The Board of Nurse Examiners can do this by issuing administrative decisions or declaratory rulings. The Department of Health Services can promulgate such decisions or rulings through the regulatory process.

The practice acts that apply to licensure of health professionals include language that prohibit unlicensed persons from practicing these professions for remuneration. Violation of the prohibitions can result in a fine and/or jail term. For example, the Nurse Practice Act (C.G.S. Sec. 20-87 through Sec. 20-102a), states that: "No person shall, for remuneration, practice nursing as defined in subsection (a) of section 20-87a, unless properly licensed" (C.G.S. Sec. 20-102). Someone found guilty of practicing nursing without a license can be fined up to $500.00 and/or imprisoned for up to five years. Furthermore, each instance of patient contact or consultation which is in violation of the Nurse Practice Act constitutes a separate offense.

The provisions of the Nurse Practice Act do not, however, prohibit "any person from domestic administration of family remedies or the furnishing of assistance in the care of

an emergency" (C.G.S. Section 20-101). It is the Board of Examiners for Nursing and the courts which decide whether someone is practicing nursing without a license.

The licensed nurse is accountable to the Board of Examiners for Nursing for his/her practice as a nurse, regardless of the nurse's responsibilities to his/her employer for employment activities. For school nurses, accountability to the Board of Examiners for Nursing for the provision of safe nursing services to students may at times come into conflict with administrative decisions regarding the assignment of school health personnel and/or the delegation of nursing functions to other school staff members. These issues will be discussed under "Delegation and Supervision" on page 20. It should be noted, however, that school nurses may be disciplined by the Board of Examiners for Nursing for failing to practice nursing according to nursing standards even when such failure occurs because of his or her employer's directive. Such discipline can result in loss of the nurse's license.

The State of Connecticut has specific regulations regarding qualifications of school nurses and school nurse practitioners. According to State Regulations, Sec. 10-212-1 through 10-212-7, school nurses and nurse practitioners must be qualified. The Regulations require that the school nurse/nurse practitioner must be a registered professional nurse, designated as RN, as defined in Section 20-87a of the General Statutes, and currently licensed in the State of Connecticut. The regulations also define what professional experience and education a registered nurse must have in order to qualify as a school nurse/nurse practitioner. These are considered minimal requirements.

Licensure

Physicians and nurses in Connecticut, as in all states throughout the nation, must be licensed in order to practice medicine or nursing in this state, that is, to provide services and perform certain functions covered within the professions' licensure acts. Licensure for medicine and nursing is based on the successful completion of required academic and clinical programs, as well as successful completion of a state qualifying examination. The intent of licensure is to ensure that those who practice as physicians and nurses, or perform the functions described within the practice acts, have met certain professional academic and clinical qualifications designed to protect the public from unsafe care. Unsafe care in medicine and nursing results in higher death rates, greater incidence of illness, injury or complication, unnecessary suffering and greater long-term expense both for the consumer and society.

According to Connecticut General Statutes, physicians in Connecticut are licensed to:

> . . . diagnose, treat, operate for or prescribe for any injury, deformity, ailment or disease, actual or imaginary, of another person . . . (or) to practice surgery . . . (C.G.S. Sec. 20-9).

The physician can delegate certain licensed functions to other licensed health care providers under his/her supervision, but not to unlicensed persons.

The practice of nursing by a registered nurse (RN) is defined in statute as:

> The process of diagnosing human responses to actual or potential health problems; providing supportive and restorative care; health counseling and teaching; performing case finding and referral; collaborating in the

implementation of the total health care regimen; and executing the medical regimen under the direction of a licensed physician or dentist [C.G.S. Sec. 20 - 87a(a)].

Nursing diagnosis, providing supportive and restorative care, health counseling and teaching and casefinding and referral are independent functions of the RN. Collaboration in the implementation of the total health care regimen and executing the medical regimen are functions that are interdependent with the physician or dentist. **Registered nurses may delegate specific functions to licensed practical nurses and to unlicensed persons under their supervision.**

The registered nurse who meets specialized postbasic education and experience requirements beyond those for RN licensure may also obtain licensure as an Advanced Practice Registered Nurse (APRN). APRNs who are so licensed, (APRN nurse practitioners and APRN clinical nurse specialists), may additionally prescribe, dispense and administer medical therapeutics and corrective measures under the direction of a physician licensed to practice medicine in Connecticut.

The practical nurse is licensed to perform selected tasks, to share responsibility under the direction of the registered nurse for the health care regimen and to carry out the medical regimen under the direction of a RN, physician or dentist. In February 1989, the Board of Nurse Examiners, in response to a request from the Connecticut general assembly, issued a declaratory ruling to clarify the role of the licensed practical nurse (LPN). That ruling states that the LPN:

- must perform his/her nursing functions and shared nursing responsibilities under the direction of a registered nurse; and
- can participate in all phases of the nursing process under the direction of the registered nurse (to the extent detailed in the declaratory ruling).

The LPN may contribute to, but may not be responsible for, nursing assessment, diagnosis, planning, implementation or evaluation of client care, nor can the LPN be responsible for implementation of the plan of care independent of the RN. In health care agencies providing in-patient and out-patient nursing services, the direction from the RN must be "immediately available and on-site." In community health settings, which includes schools, the RN "must be responsible for the total plan of nursing care and should be proximately available for on-site visits and available by telephone." The latter ruling assumes that the RN has determined that the condition of the client(s) is (are) stable enough to delegate client care to the LPN and that the RN has sufficient time in his/her schedule to provide appropriate on-site clinical supervision.

Because of the complex health care needs of students in schools today, the Connecticut Advisory School Health Council, in its 1989 *Guidelines on the Roles and Qualifications of School Health Personnel,* recommended that LPNs should be utilized in schools **only** where **on-site** supervision of the registered nurse is available. This is not a legal requirement. However, the RN must consider this recommendation and the complexity of care potentially required by the student(s) before determining that it is safe for a LPN to function in a school setting without on-site supervision. If the RN delegates care to a LPN in a setting where the RN is not on-site, the RN must determine the amount of on-site supervision that must be provided to ensure safe care and the RN remains responsible for the care provided.

Excerpts from the Connecticut licensure statutes for health professionals who work in schools are included in Appendix A.

Standards of Practice

In addition to state licensure and regulations for health professionals and the rulings or decisions of the respective Boards of Examiners for medicine and nursing, there are numerous and complex standards within medical and nursing practice that define other criteria for an "expert" in a specialty or subspecialty area of practice. In medicine, for example, specialties include psychiatry, pediatrics and orthopedics, while subspecialties in the area of pediatrics and psychiatry include neonatology, adolescent medicine, developmental pediatrics and child psychiatry. Physicians must obtain further education and clinical experience, plus pass an additional board certification examination, in order to specialize in an area of medicine beyond "general" practice.

Nurses also must obtain further clinical experience and, generally, further education, plus pass a national certification examination in order to become certified as an expert nurse in a specialty area. (Such national certification must not be confused with the Connecticut Department of Health Services' licensure of, or requirements for, Advanced Practice Registered Nurses.) In nursing, specialty areas may include pediatric nursing, community/public health nursing or psychiatric nursing. Further nursing subspecialties in these areas include, for example, neonatal nursing and school nursing. As of 1991, the National Board for Certification of School Nurses, Inc., certifies school nurses and requires RNs to have a baccalaureate degree. This certification is not required to practice, but is a standard that school districts can consider when hiring new personnel, encouraging present personnel to pursue continuing education or developing salary incentives. Families should also know the preparation and expertise of the health care professionals providing services to their children.

There are additional standards of practice in nursing and in medicine that can be used in a court of law to demonstrate whether the nurse or physician met the required standard of care in a specific instance. These standards are generally developed and published by a profession's national organization or related organizations such as the Joint Commission on the Accreditation of Hospitals. They are valuable to health professionals in planning, administering and evaluating appropriate services and to clinical supervisors in evaluating the health professional's performance. National standards for school nursing practice, developed by five nursing organizations, were first published by the American Nurses Association in 1983 and are currently being revised. In addition, there are numerous other standards for nursing practice, including the American Nurses Association Code of Ethics (1976), that might apply in the school setting.

Delegation and Supervision

Based on licensure laws and regulations, individuals who are not licensed to practice nursing may not carry out nursing functions or tasks in the school unless they do so under the delegation and supervision of the registered professional nurse. Before delegating a task, the professional nurse must assess the health status of the client and determine, **for each individual client,** whether a specific nursing function or task can safely be performed by an unlicensed person (with training and ongoing supervision). The decision of whether or not to delegate a nursing task is based on the stability of the client's condition, potential complications, the need for professional judgment during the task, whether a license is required for the specific task and related factors. To whom the activity will be delegated should be determined collaboratively with the school administrator and other appropriate school personnel. Furthermore, the

delegation of a specific nursing activity to other school personnel may be limited by collective bargaining laws and by the job descriptions of those employees.

According to the National Council of State Boards of Nursing, in its *Concept Paper on Delegation*, 1990:

> . . . licensed nurses, in accordance with board of nursing requirements, determine the appropriateness of delegating acts from their scope of practice. Each person involved in the delegation process is accountable for his/her own actions in this process. There is potential liability if competent, safe care is not the outcome of delegation.

They defined **delegation** as:

> transferring to a competent individual authority to perform a selected nursing task in a selected situation;

and **supervision** as:

> provision of guidance by a qualified nurse for the accomplishment of a nursing task or activity with initial direction of the task or activity and periodic inspection of the actual act of accomplishing the task or activity.

It is further stated in the paper (see Appendix B) that "total nursing care of an individual remains the responsibility and accountability of the nurse."

Certain critical functions of the professional nurse, in particular **the assessment, diagnosis and planning aspects of nursing care, can never be delegated** to unlicensed persons, nor can specific tasks (for example tracheostomy care and suctioning) be delegated when the State Board of Examiners for Nursing prohibits such delegation, as in the state of Connecticut. A nurse can be disciplined by this board if he/she uses poor nursing judgment in delegating a task or function, provides inadequate training or supervision, delegates tasks that have been prohibited by the board, or in some other way puts the client (student) at unnecessary risk for harm. Disciplinary measures may include revocation of the nurse's license to practice. In addition, the nurse would certainly be at increased risk for liability in a related negligence law suit.

Each student must be assessed individually by a school nurse before the decision can be made that it is safe to delegate a nursing activity. For example, unlicensed persons can usually assist special needs students with putting on or removing an article of clothing. However, in the rare instance that a student is at high risk for bone fracture with movement and handling, the school nurse would not delegate to an unlicensed person the task of assisting this student with clothing. In another situation, the school nurse may determine that it is safe to delegate the monitoring of a drip method gastrostomy feeding. After the nurse determines that it is safe to delegate this function, the school administrator and school nurse, together with other appropriate persons such as the classroom teacher, should determine together who might best be assigned the task of monitoring the feeding. The designated employee should be willing to take on the responsibility and it should be within the scope of his or her job description.

Other licensed health care providers, such as physical therapists and physicians, also must determine when it is or is not safe to delegate tasks within their scope of practice. Such delegation decisions are made according to state law, regulations, board decisions and client-specific criteria similar to those applied in nursing. Because there are

overlapping practice areas across health professions, more than one school health professional may be licensed to perform the same function and to make related delegation decisions. For example, the physical therapist, occupational therapist and school nurse are all licensed to perform range-of-motion exercises. Each must do so in keeping with the regulations and standards of practice for his/her own profession. However, decisions by other health professionals to delegate such care in the school setting should be done in collaboration with the school nurse and based on the total health status of the individual student.

Practice By Unlicensed Persons

In the state of Connecticut, individuals may be jailed for up to five years and fined up to $500, or both, for practicing without a license the following health professions: medicine, nursing, occupational therapy, physical therapy, psychology (not applicable to certified school psychologists or school psychological examiners not licensed by the Department of Health Services as a psychologist under C.G.S. Sec. 20-187a), speech pathology and audiology. This means that there can be criminal, in addition to civil, consequences if a school employee performs the licensed function of one of those health professionals when the function or task has not been (or cannot be) delegated by the licensed professional. Such licensed functions of health professionals include, for example, assessment of the student's health status, development of a plan to meet the student's health care needs in school, or the performance of a health care procedure that has not been (or cannot be) delegated by the appropriately licensed professional.

In a court case in Oregon (see *Carol Mitts v. Hillsboro Union High School District No. 3, et al., Washington County Circuit Court, Case No. 87-11420*), a school district was sued by a school health assistant because the school principal assigned the health assistant (an unlicensed school employee) to perform clean intermittent catheterization (CIC) on a new middle grade student with spina bifida, following training by the mother and with intermittent supervision by the part-time school nurse. The court asked the Oregon State Board of nursing for a declaratory ruling in the matter. The Board's ruling is as follows:

> . . . the central conclusion is that unlicensed persons in the school setting may be required to perform tasks of nursing care when those tasks are properly delegated to them by a registered nurse. Unlicensed persons may not perform those tasks on their own volition nor be required to perform those tasks when directed to do so by school authorities or parents.
>
> The issue here is not merely the performance of CIC in a school setting, and who may perform it. Rather, the issue is the identification of health care needs of students and how best to meet those needs. The purpose of hiring individuals with various areas of expertise and credentials in the school setting, is to utilize their knowledge and skills to provide students with an environment for learning and the provision of related services. A nurse employed by, or under contract to, a school system must be allowed to use her skills and expertise in the nursing process to meet identified health care needs of students. The law requires no less.

The Oregon State Board of Nursing concluded that the principal was unlawfully practicing nursing without a license, not so much because he assigned the simple task of CIC, but rather because he presumed to understand the health care needs of the student (i.e., assumed the functions of health assessment, diagnosis and planning) for which he

was neither qualified nor licensed. The Board also determined that the school nurse had not acted according to professional nursing standards. A footnote to the declaratory ruling states:

> The Board expects that licensed nurses take an active role in applying the nursing process. (The school nurse's) role was passive in that she accepted the assessment by school authorities regarding (the student's) health care needs and acted upon that assessment by supervising (the health assistant).

In an additional footnote to the declaratory ruling, the Oregon State Board of Nursing noted that health assistants in school districts in Oregon were apparently being required "to engage in systematic problem solving which includes the steps of assessing, making nursing diagnoses, planning, intervening and evaluating. This constitutes the practice of nursing which health assistants may not lawfully do unless they are properly licensed."

Training of School Personnel by Parents. While the licensure acts do not prohibit parents from learning and providing specialized care to their own children, parents cannot take on the responsibility for teaching others to provide such care, nor can they unilaterally determine the best plan of care for their child in the school setting. Based on the practice acts for health professionals, it is illegal for school personnel to provide health care to a student based on instruction by a parent. This does not mean, however, that parents should not collaborate with the school nurse, for example, in developing a plan of care and in preparing other school personnel for their child's entry into school. Since the parents have expertise about the individual strengths and needs of their child, it is critical that they collaborate with the school nurse in preparing other school personnel to provide a safe environment for their child. Even if a parent is a licensed nurse, the parent cannot take on the sole responsibility of training school personnel to provide specialized care since the parent is not part of the school's organizational structure and will not be responsible for the ongoing care of the student in school or for the supervision of other personnel providing care. The school system must ensure that the school nurse completes a health assessment of the student, determines that delegation of care is appropriate in the school and is well prepared to train and supervise other school personnel to whom care is delegated.

Transdisciplinary Functioning. Transdisciplinary team functioning, currently promoted in early intervention models, is defined as "a team approach that involves members from varying disciplines teaching, learning and working together with or as providers of service across traditional boundaries" (Connecticut State Department of Education, 1991). Interpretations of this definition are varied, but include the concept that all team members teach each other how to carry out one another's professional functions. One member of the team is then designated as the "prime interventionist" for each child/family. The goal is to minimize duplication, confusion and other inefficiencies that occur when multiple service providers function separately in serving a child and family. Such transdisciplinary functioning is potentially efficient and effective when staff are crossing professional boundaries within **shared** areas of knowledge and expertise. **Transdisciplinary functioning does not, however, obviate the necessity for professional assessment, delegation, and supervision in areas of responsibility covered by licensure.** It is absolutely **unsafe** and **illegal** for individuals to assume that they have adequate theoretical and clinical knowledge and skills to provide health services without individual child assessment, delegation, personnel training, supervision and evaluation by the licensed health professional. It is unsafe, unethical and, in most instances, illegal for health and education professionals to practice in areas for which they have not received the formal

education, supervision, and experience or passed the licensure or certification examinations required by law and professional standards. To do so is putting the health and welfare of students at unnecessary risk. Truly effective teamwork, in which the family and all team members work in collaborative and coordinated relationships, each recognizing and utilizing effectively the expertise of one another while teaching, learning and working together, should serve to minimize duplication and inefficiencies without jeopardizing the quality of care provided. It will also serve to minimize the potential liability of school personnel and school districts in serving students with health care needs in school.

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POLICY AND PROCEDURE DEVELOPMENT

School districts need to have in place policies and procedures which ensure that students with special health care needs can receive an appropriate individual education in a safe environment. A safe environment implies that such students will receive those health care services necessary to maintain, and wherever possible to improve, their health status so that the students may derive benefit from their educational program. To maintain one's health status means to stay as healthy and functional as possible, to prevent deterioration in one's condition and to maximize one's ability to develop normally. The responsibility and accountability for decision making related to such services in the school should be clearly defined in the district's policies and procedures to ensure the safety of, and confidentiality of information about, all students with special health care needs.

The following principles provide a sound basis for the development of policies and procedures in schools or other settings where educational services are being provided and are applicable to all students, age 0-21 years, who are entering or in school programs.

1. Every student is entitled to a free, appropriate public education in the least restrictive environment.

2. The process of planning for, providing and evaluating health services for individual students with special health care needs in school must be child focused and family centered.

3. The process of planning, providing and evaluating health services for individual students with special health care needs in school requires collaborative decision making among administrators, school nurses, teachers and other members of the school team. **The school nurse must play an integral role in the decision-making process.**

4. Lines of decision making, responsibility and communication must be clearly identified within the organizational structure. See the section *The Decision-Making Process* for further guidelines in this area.

5. The current health status and health needs of students with identified or potential special health care needs, whether physiological or psychological in nature, should be assessed by the school nurse. Determination of the health status and health needs of students with known health impairments that are psychological in nature may necessitate collaborative assessment with a school mental health professional such as a school social worker, psychologist or psychiatric nurse specialist.

6. When a student requires health care in school, an Individualized Health Care Plan (IHCP), based on a comprehensive nursing assessment, should be developed by the school nurse in conjunction with the parent/guardian, the student's health care providers and the student, when appropriate. The school administrator, nursing supervisor, school medical advisor, classroom teacher and other pupil

personnel specialists should be consulted and informed during this process and should participate in developing the IHCP, as appropriate. Who is "consulted or informed as appropriate" will depend on the age, grade level and developmental needs of the student body, the number of students in the building, the personnel available, lines of administrative and clinical decision making and the age, health condition and the health service and confidentiality needs of the individual student. For further details, see the section *Entry/Re-Entry Process.*

7. Whenever a student needs health care services or monitoring by school personnel other than the school nurse, a planning meeting should be scheduled. At this meeting, school adaptations necessary for implementation of the student's health care plan and further details of the IHCP should be defined. The planning meeting should include the family, the school nurse, the school administrator, school personnel who will be responsible for monitoring the student or providing specific services, and transportation personnel and community health care providers, as appropriate.

8. The IHCP should delineate:
   - the student's health care needs and related adaptations required in school;
   - responsibilities for service delivery;
   - training needs of, and other resources required for, personnel to implement the plan;
   - designation of a school liaison for the family; and
   - frequency of review and evaluation of the plan.

9. Whenever a student's health status appears to adversely affect his/her educational performance, he/she should be referred to the planning and placement team for special education eligibility evaluation. If the student is eligible for special education, it is appropriate to incorporate the student's individualized health care plan (IHCP) into the IEP.

10. Prior to attendance in school of students with special health care needs, the following should be planned and arranged for in a timely manner, as specified in the IHCP:
    - personnel qualified to provide necessary care and services;
    - appropriate training, supervision and/or consultation for staff;
    - safe and appropriate transportation;
    - supplies, equipment and medications necessary for the student's care; and
    - a safe environment.

    These are in addition to the health assessment and immunization requirements mandated by Connecticut General Statutes, Sections 10-204a and 10-206.

11. When the administration or supervision of special health care procedures or treatments in school requires a physician's order and parent authorization, both the detailed order or prescription and the parent's permission must be received in writing before the procedure or treatment can be administered in school.

12. Health care services in school should be provided in a manner consistent with national, state and local standards for health care services and professional practice.

13. Specialized health care procedures must be adapted to the needs of the individual student and should be performed by qualified personnel.

14. When licensed professionals delegate selected procedures to other personnel, the licensed professional remains responsible for supervision of those individuals carrying out the procedures and for the quality of care provided.

15. To the degree possible, the delivery of any health care procedure should minimize disruption to the educational process of the individual student.

16. To the degree possible, the delivery of any health care procedure to an individual student should minimize disruption to the educational process of other students.

17. Education, health care and transportation personnel may require continuing education, clinical consultation and/or child-specific (in-service) training to assure competencies in the delivery of services.

18. Infection control policies and procedures should be in keeping with current public health standards and regulations of the Occupational Safety and Health Act (29 C.F.R. Section 1910.1030).

19. Appropriate resources should be available to the personnel who are providing school health services for students with specialized health care needs and environmental conditions must be safe for students and personnel.

20. The student's and family's right to confidentiality and privacy must be protected. School personnel are responsible for maintaining such confidentiality except when it is necessary to share information about the health status of a student for the protection of the student, of other students or of school personnel. When confidentiality is an issue, consultation with the parent, school medical advisor, school nursing supervisor and the primary care physician is advisable.

21. Policies and procedures regarding school health records must be in keeping with:
    - state and federal education laws;
    - federal and state confidentiality laws;
    - state and federal health laws;
    - standards of practice for nursing and medicine; and
    - records Retention/Disposition Schedules for Municipalities/Towns, Schedule V, Education Records.

    An in-depth explanation of the complex issues involved in developing such policies and procedures can be found in Appendix E, a reprint of the article *"School Health Records: Nursing Practice and the Law."* The State Department of Education recommends the development of systems consistent with recommendations in the article, in particular, the development of a nursing record separate from the Cumulative Health Record (CHR-1).

Based on the above principles, school districts may need to develop, review, update and revise other policies and procedures related to the education of students with special health care needs. These policies and procedures may relate to a variety of areas, including, but not limited to:

(a) organizational structure (decision making)
(b) personnel
(c) school entry and re-entry
(d) instructional programs
(e) essential resources
(f) staff development
(g) records (access and retention)
(h) infection control
(i) equipment maintenance
(j) transportation

ORGANIZATIONAL STRUCTURE: THE DECISION-MAKING PROCESS

The internal organizational structure of the local school district should reflect and support the collaborative decision making of educators and health professionals at all levels of the organization. With the increasing complexity of health services required by students in school, both administrative and clinical judgments are critical in planning, implementing and evaluating services for children with health impairments. Local school districts may need to review and revise organizational structures, policies and procedures in order to promote decision making which is truly collaborative in nature and to ensure that both administrative and clinical judgments are made by those who have the expertise and legal authority to make them.

It is important at the classroom level that team members (for example, the teacher, mental health professional, school nurse, physical therapist, occupational therapist and speech-language pathologist) provide coordinated services with common, **child-focused and family-centered** goals. In order to do this, team members, including the family, must share information necessary to optimize the student's educational program and to ensure the student's health and safety. Similarly, it is essential that school administrators, school nurse supervisors, school medical advisors, pupil personnel coordinators and other appropriate supervisory and administrative personnel collaborate in planning programs, developing procedures and resolving many of the difficult issues inherent in providing services for students with special needs. Finally, the local board of education should ensure that health-related issues are identified and considered in the process of developing and revising policy by consulting with the medical advisor, nursing director and community health experts. At times, consultation with lawyers who have expertise in the health field, in addition to those who have expertise in education, may be beneficial in resolving legal issues regarding district policy or procedure.

The local school district has the overall responsibility for providing an appropriate education in a safe environment for its students. In order to discharge its administrative responsibilities as they relate to the health care of students in school, the local school district should:

- hire qualified health professionals who are competent to provide consultation, training, supervision, and/or direct health care services for the specific student population served;
- ensure interdisciplinary collaboration in the development of policies and procedures;
- establish clear lines of authority, responsibility and accountability for clinical decision making;
- develop policies and procedures which ensure that clinical decisions related to the health status and health care of students are made by health professionals who are qualified and legally authorized to make such decisions;
- delegate the responsibility for developing clinical policies, procedures and protocols specific to the delivery of health care services in the district to appropriately qualified health and mental health clinicians;

- delegate the authority and responsibility for making clinical decisions to the health and mental health professionals who are qualified to make them;
- consult with community health experts or utilize a health advisory committee which includes such experts;
- develop policies which ensure appropriate privacy and maintenance of confidentiality around student health information, third-party medical/psychiatric records and school health records; and
- establish mechanisms for interdisciplinary planning, joint problem solving and collaborative evaluation of student services.

The school health professionals, on the other hand, have primary responsibility for:

- safe clinical services;
- the development of sound clinical policies, procedures and protocols; and
- final decision-making authority in the clinical aspects of health care delivery within the school system.

School administrators, educators, medical advisors, school social workers, school nurses, speech/language pathologists, school psychologists, school counselors, physical therapists, occupational therapists, transportation supervisors and other professionals within the school and community need to collaborate in the development, review and revision of related policies, procedures and student services on a regular basis. Mechanisms which promote **joint planning, joint problem solving and joint service evaluation** will foster sound decision making and avoid unnecessary conflict among personnel.

The vast majority of school decisions related to serving students with special health care needs require some combination of both administrative judgment and clinical judgment. It is sometimes difficult to identify the specific components of the decision-making process, but it is important to make a collaborative effort to do so. When the various components of a decision-making process can be identified, they can then be developed into a procedure, protocol or decision tree chart for the future management of similar issues.

Example of Collaborative Decision Making

A new student is eligible to enter the preschool program located in a district's elementary school. Because of the student's health impairment, he/she will require a health care procedure daily while in school. In the process of planning for this student to enter school, the decision about who should perform the required procedure must be made. The steps of a collaborative process for making this decision, including both administrative and clinical components, as well as the primary responsibility for specific aspects of the decision, are outlined below. Although the primary responsibility for each decision is indicated by "CLINICAL" or "ADMINISTRATIVE," **in most instances the decision maker will make better judgments when others have been consulted during the decision-making process.**

1. The school nurse initiates a health assessment and, in consultation with the student's physician, family and other appropriate persons, determines:

    - what level of care is required by the student;

- that, in this case, the procedure can be delegated to nonlicensed personnel; and
- that the nonlicensed personnel should have professional-level judgment skills.
  (CLINICAL)

2. The administrator determines:

   - which professional staff members are available to perform the procedure; and
   - whether the job descriptions of these personnel permit the performance of such assigned health procedures.
     (ADMINISTRATIVE)

3. The administrator, after consultation with the potential candidates and the school nurse, chooses the individual professional (certified staff member) who is most suitable to provide the care at the specified level.
   (ADMINISTRATIVE)

4. The school nurse trains the individual designated by the administrator, determines when the individual is sufficiently competent to provide care, and regularly supervises him or her.
   (CLINICAL)

5. When the student's health status changes, the nurse, in consultation with the student's physician, family and other appropriate persons, determines that the level of care required by the student can no longer be provided by an unlicensed individual.
   (CLINICAL)

6. The school nurse recommends that care be provided by a school nurse until such time as the student's condition stabilizes again.
   (CLINICAL)

7. The administrator immediately arranges to implement the recommendation; or, if regular staff are not immediately available, the administrator makes an alternative interim plan (which still meets the level of care recommended by the school nurse, such as reassigning a school nurse part-time from another building) while exploring the district's options and obtaining further consultation.
   (ADMINISTRATIVE)

8. The administrator, family, health professionals, teacher, pupil personnel specialists and outside consultants may all need to problem solve together in order to come up with a viable plan to meet the student's needs at the new level of care required.
   (COLLABORATIVE)

It is essential for all personnel to recognize that there will be conflicts and problems which arise in the process of planning for, providing and evaluating the special services that students with special health care needs may require in school. Such conflicts will most often be based on one of the following problems:

- limited resources, including personnel and time;
- lack of knowledge, understanding and/or trust on the part of health and education professionals about each other's practice and expertise; or
- ineffective team communication and collaboration due to inexperience of personnel, interdisciplinary "turf" issues or lack of systemwide commitment to providing quality services to students with special health care needs.

It is important, therefore, for school districts to provide adequate orientation of personnel to interdisciplinary team functioning, to promote regular team meetings for communication about issues and problem resolution, and to define for all personnel an administrative structure that clearly establishes proper lines of responsibility and authority for administrative and clinical decisions, for joint decision making and for recourse when the first line of problem resolution is not effective. Indeed, the health, safety and even life of a student may depend on clear lines of decision making among personnel.

Policies and procedures related to personnel should be reviewed and revised as needed to reflect the health needs of the school community. The type and number of regular and consultant staff members that a school district may require will depend on the student population served and may vary over time. The role descriptions for school health personnel that were developed by the Connecticut Advisory School Health Council (C.A.S.H.C.) in 1988, "Roles and Qualifications of School Health Personnel," serve as an excellent reference for school districts in developing job descriptions (see Resource list at the end of this section). It is important to note that these role descriptions suggest minimum qualifications for school health personnel which may not be adequate for school populations with significant numbers of students with moderate to severe health impairments.

The following principles and guidelines should serve as a basis for policy and procedure development in the area of personnel planning, hiring, role delineation and related personnel issues regarding the provision of services for students with special health care needs.

General

1. The school medical advisor and school nurse supervisor/director should be integrally involved in the development of personnel policies and procedures as they relate to school personnel working with students with special health care needs.

2. In school districts where there is no nursing director/supervisor (i.e., a professional nurse with supervisory or administrative responsibilities), the most qualified school nurse in the district should participate in the development of such policies and procedures.

3. Consultation with other disciplines and with outside community experts in nursing, medicine and related health fields is beneficial and may be essential.

4. School districts should examine the health service needs of the total student population to determine safe and appropriate staffing patterns.

5. Job descriptions should clearly delineate roles, responsibilities and lines of authority and, for professional personnel, should be based on the standards of practice for the profession. The C.A.S.H.C. guidelines referenced above are based on such standards of practice for nursing and medicine.

6. Personnel policies and procedures should require personnel to use (1) appropriate infection control techniques to prevent the unwarranted spread of communicable diseases (see the section *Infection Control*) and (2) universal precautions, when indicated, to prevent exposure to bloodborne viruses including human immunodeficiency virus (HIV) and hepatitis B virus (HBV) [see OSHA Instruction CPL 2-2.44A, U.S. Department of Labor].

7. Hepatitis B immunization must be offered free of charge to school nurses and other health care and first aid providers who, in the course of their regular responsibilities, are exposed to blood and/or other body fluids considered high risk

for the transmission of hepatitis B [OSHA Instruction CPL 2-2.44A, U.S. Department of Labor]. See also the section *Infection Control.*

8. Before a licensed health professional assigns a task to unlicensed personnel, it is necessary to determine that the employee's job description does not prohibit the performance of such a task.

Qualifications for Regular, Contract and Substitute Personnel

1. School districts should hire qualified personnel based on the standards of the specific profession, and subspecialty when applicable, and the needs and ages of the students to be served.

2. School districts should ascertain that licensed health professionals whom they employ are in good standing in their professions and are currently licensed to practice in the state of Connecticut (see Appendix A for Connecticut General Statutes regarding licensure of health professionals).

3. School districts should ascertain that licensed and certified health professionals whom they employ have clinical experience relevant to providing services for children and families.

4. A school nurse must have **no less** than the minimum (entry level) qualifications mandated for both educational preparation and relevant professional experience under Connecticut General Statutes, Section 10-212. In many instances, the school district may prefer to seek professional nurses, nurse practitioners, or clinical nurse specialists, who, in keeping with current standards within the profession, have additional educational preparation, clinical experience or both relevant to the provision of specialized health services to children in the school setting. At the master's degree level, nurses are prepared in subspecialty areas such as pediatrics, psychiatry and public health. Additionally, some of these nurses have expertise with infants, toddlers and preschoolers, while others have expertise with school-age children or adolescents.

5. All professional and paraprofessional staff members, as well as appropriate contract and substitute personnel, who may be the first responders to a medical emergency should obtain CPR certification prior to employment and should maintain current CPR certification throughout employment.

6. All personnel should be knowledgeable about proper procedures for infection control and universal precautions and should routinely utilize them, as appropriate.

7. Contract personnel, such as physical and occupational therapists, should have the same qualifications for employment as required of employees. Contract personnel should be required to demonstrate participation in continuing professional education in an area of practice relevant to services for children in the school setting.

8. Substitute personnel, such as substitute nurses or substitute teachers, should have the necessary knowledge, skills and supports available to carry out the health service responsibilities of regular personnel.

9. Orientation of substitute personnel to school buildings and to individual students with specialized needs, as well as supervision of their performance, is essential for maintaining a safe environment during the absence of regular personnel.

10. Any decision to hire a health aide should be made collaboratively with the school nursing supervisor/director or school nurse and the school medical advisor. Health aides are intended to assist the school nurse and should work under the direct (on-site) supervision of the nurse. When a health aide is going to be hired, the school administrator should collaborate with the nursing supervisor or school nurse in the development of the job description and in the selection process.

11. If a health aide is hired to assist the school nurse in the school health office, the health aide should **minimally** have CPR certification and first aid training. The health aide is further trained by the school nurse in confidentiality and privacy requirements and other responsibilities of the position and remains under the supervision of the school nurse.

Planning for the Absence of Staff Providing Health Services

1. There should be a back-up plan that can be implemented when staff members providing health services are absent or are not available to provide care so that students can continue to attend school and receive safe care. The back-up plan may include designating another staff member, who has already been trained and is competent to care for the student, to be the substitute on a short-term basis, or it may include reassigning a nurse from another building for the day.

2. If the care of an individual student is complex, the school district may have to inform the student's family that, for safety reasons, the student may not come to school when the back-up plan cannot be implemented due to an unexpected circumstance or no competent substitute is available to provide the care.

3. Whenever a back-up plan does fail and a student must stay home due to inadequate staffing, the causes should be evaluated and steps should be taken to avoid similar circumstances in the future, including revision of the back-up plan.

Consultation, Supervision, Continuing Education and In-Service Training

1. Health professionals employed in school districts are practicing outside the mainstream of their profession and need regular opportunities to update their clinical knowledge and skills. School districts should require that health professionals regularly access continuing education opportunities that are **appropriate to their professional practice**.

2. High-quality care for students may depend on the professional's ability to keep current with rapidly changing scientific and technological advances in the health care field and with changes in the application of these advances to the provision of individualized health care services.

3. Participation by school health professionals in continuing education designed for classroom teachers, while advantageous in some ways, will not suffice to keep the health professional up-to-date in his/her area of professional expertise.

4. All staff members providing health care services should have clinical supervision by health professionals qualified to provide such supervision; they should also have access to consultation with expert health professionals.

5. In-service education and appropriate training of personnel may be necessary **prior to the entry or re-entry** of a student with complex physical or mental health needs in order to ensure the safety of the student or other students in the school.

6. Such advance preparation must be provided as rapidly as possible so as not to become a barrier to the student's earliest entry or re-entry into school.

7. Nonprofessional staff members, including transportation drivers, aides and security personnel, require ongoing, general in-service education and student-specific training related to health care activities and emergency assistance for which they may be responsible.

8. Nonprofessional staff members, including transportation drivers, aides and security personnel, require appropriate supervision on the job.

9. Personnel who have regular or potential contact with body fluids that are not high risk (urine, feces, saliva, tears, nasal discharge, and vomitus without visible blood) should have ongoing general and specific instruction in the principles, appropriate utilization and implementation of infection control techniques.

10. Personnel who have regular or potential contact with high-risk body fluids (blood, vaginal secretions, semen, cerebrospinal fluid or other body fluids containing visible blood) should have ongoing general and specific instruction in the principles, appropriate utilization and implementation of universal precautions.

11. Depending on the student population served, teachers, pupil personnel specialists, administrators, nonprofessionals and/or transportation personnel may require ongoing regular education and supervision in one or more of the following areas:

    (a) CPR;
    (b) first aid, including recognition of potential medical emergencies/anaphylaxis;
    (c) body mechanics/lifting procedures;
    (d) seizure management;
    (e) maintenance of confidentiality;
    (f) documentation;
    (g) child abuse, recognition and reporting; and
    (h) youth suicide prevention.

12. Other areas that may need to be incorporated into ongoing training for principals and certified staff members, depending on their responsibilities for medication administration and according to Connecticut General Statutes and Regulations, include:

    (a) injection technique;
    (b) principles of medication administration; and
    (c) student-specific medication training.

Delegation of Health Activities; Interdisciplinary and Transdisciplinary Team Functioning

1. The health care professional **cannot be required to delegate** a task to another staff member (who is either less prepared or not licensed) when the health professional determines that such delegation may put the student at risk for receiving unsafe or poor-quality care or if, in the case of nursing, for example, the Board of Examiners for Nursing has determined that such licensed function cannot be delegated. (See Appendix L.)

2. When a health professional delegates tasks to other personnel, that health professional is responsible for the training, assessment of competencies, ongoing supervision and related evaluation of personnel to whom the tasks are delegated.

3. Licensed health care personnel are obligated to function at a level commensurate with their license, but should not be required to perform new or unfamiliar procedures until they have received adequate preparation.

4. Health care professionals, such as the school nurse or physical therapist, may require outside professional consultation and/or education in order to learn a new technique or application of new technology before providing specific services to a student. In addition, special equipment, equipment training, resources, materials and reference information may be required.

5. Other school personnel, including certified and paraprofessional staff members, must not be required to take on delegated tasks and responsibilities until (1) they have been adequately prepared and assessed for competency by the responsible health professional and (2) a plan for regular and ongoing supervision is in place.

6. In general, the classroom teacher should not be designated to provide specialized health care services to individual students when doing so would represent an unwarranted commitment of time to the potential detriment of other students in the classroom. Exceptions may be necessary in an emergency situation.

7. Interdisciplinary collaboration among personnel and families is essential in all phases of planning, implementation and evaluation of services for students with special health care needs in school.

8. Effective collaboration requires regular communication and time for joint planning and problem solving by supervisors and staff members involved in the provision of health services to students in school. The staff may vary according to the needs of the student and may include teachers, administrators, school medical advisors, school nurses, school social workers, school psychologists, school counselors, speech-language pathologists, occupational therapists, physical therapists, paraprofessionals, transportation personnel, food services personnel and outside consultants.

9. All members of the team, including family members, must recognize the expertise of others, learn to utilize one another effectively and collaborate accordingly.

10. Transdisciplinary functioning is potentially efficient and effective when staff members are crossing professional boundaries within *shared* areas of knowledge and expertise. **Transdisciplinary functioning does not obviate the necessity for professional assessment, delegation and supervision in areas of responsibility covered by licensure or specific to the expertise of a particular discipline.**

11. It is absolutely unsafe and illegal for individuals to assume that they have adequate theoretical and clinical knowledge or skill to provide services outside their own area of expertise without individual child assessment, delegation and personnel training, supervision and evaluation by the appropriate professional.

12. The clinical assessment responsibilities of one discipline absolutely cannot be assumed by a member of another discipline. It is unsafe, unethical and, in most instances, illegal for health and education professionals to practice in areas for which they have not received the formal education, supervision and experience, or passed the licensure or certification examinations required by law or by professional standards.

13. Health assessment is the unique responsibility of physicians and registered nurses and cannot be delegated to other personnel.

14. Teachers, other certified personnel and noncertified staff members cannot take on the licensed responsibilities of any health professional unless the responsibility is delegated, the teacher or other staff member is supervised and the child's health status continues to be monitored by the delegating health professional.

15. Each member of the team must understand his or her unique responsibilities and expertise, as well as his/her own limitations and those of other members of the team.

Resource

Connecticut Advisory School Health Council. 1989. *Roles and qualifications of school health personnel.* Available through the State Department of Education, Bureau of Special Education and Pupil Personnel Services.

ENTRY/RE-ENTRY PROCESS

It is the responsibility of local school districts to promote and ensure the earliest possible entry into school of any eligible child; indeed, unnecessary barriers to immediate school entry have uniformly been deemed illegal by the courts. There are, however, a few "necessary" restrictions to entry which exist in Connecticut law in order to protect the health of an individual student, others in the school building or the community in general. Connecticut General Statutes require that **prior to entry** into school, students must show proof of (1) a health assessment and (2) a completed program of immunizations or initiation of an ongoing schedule of immunizations to meet the requirements.

The intent of these mandated restrictions on school entry is fourfold. First, they are intended to prevent students from entering school with communicable diseases that may put others at risk, e.g., active tuberculosis. Second, they serve to ensure that adequate levels of immunization are maintained in the community to prevent outbreaks of those diseases controlled through immunization. Third, they function as a screening for the identification of children with previously unidentified health conditions that may be cured or ameliorated with proper treatment, or of students with inadequate immunization protection. Finally, the mandate for health assessment prior to entry is intended to ensure that students with chronic or significant health conditions are assessed for special needs in school and that health care providers communicate those needs to school health personnel who can then plan for appropriate school adaptations, services or monitoring. In the large majority of cases, these health requirements are sufficient to protect the safety of the student and others, and school entry can proceed as rapidly as these basic requirements are met. Assessment and planning for special services, program adaptations and/or the development of a health care plan, if indicated, can proceed at the time of and/or after the student's entry into school.

For some students, however, entry or re-entry into school requires a more complex process. These students have known health conditions which may require:

1. advanced planning to ensure appropriate management of a potential physiological or psychological emergency in school;
2. advanced preparation of personnel, the environment and other protections necessary to prevent deterioration in the student's health condition while in school; and/or
3. specialized health services.

In order to accommodate these students safely, it is critical that school districts, regional educational service centers and other educational settings develop a process to ensure assessment of the student's individual health and safety needs in school and sufficient preparation of both personnel and the environment **before entry** occurs. This assessment and planning process, while requiring some delay in school entry, should serve to minimize risks to the student once in school and to maximize his/her potential to benefit from the educational program. When possible, advanced notification of schools by the parent/guardian and primary health care provider may allow the school adequate preparation time and eliminate the need for a delay at the desired time of entry. When advanced notification is not feasible or has not occurred, delay in entry must be restricted to the *absolute minimum* time necessary to prepare for safe entry into school. If, for any reason, this delay may be longer than three weeks, an

alternative education program, such as interim homebound, should be **immediately** developed and implemented until entry can proceed.

Guidelines for developing appropriate entry procedures for new students and re-entry procedures for students who have been absent due to illness, injury, hospitalization, or outside placement in an educational program are outlined below. When implemented, such procedures should promote:

- family and professional collaboration;
- a safe environment; and
- the provision of appropriate health services.

While procedures should be both straightforward and consistent, they should also be flexible and based on the collaborative judgments of families and professionals. Additionally, the process may vary depending on the point of entry/re-entry, age of the child, presenting health need of the child, established family-professional relationships and other factors. Despite such variations, however, the health assessment component of the entry/re-entry process is essential for all students with known or potential health impairments, whether physiological or psychological in nature. For example, when a student's presenting health need is behavioral or psychiatric in nature, the school psychologist or school social worker often takes the leadership role in the process of educational assessment and planning. This process is further enhanced when the mental health professional closely collaborates with the school nurse in the health assessment and development of the Individualized Health Care Plan. Refer to the section *Policy and Procedure Development* for further clarification.

Entry (or Re-Entry) Process by Type of Student

A. Prospective student with known special health care need that has minimal risk for emergency/crisis or deterioration of health status in school and no known educational handicap; requires health services only.

Examples:

- Student with strep throat requires short-term antibiotics.
- Student with seasonal respiratory allergies requires intermittent medication.
- Student with HIV infection and stable health status requires monitoring only.

1. Prior to entry the parent/guardian notifies the school nurse or school ad-administrator that the student may require health services or monitoring in school. This should be done as early as possible, for example, at kindergarten registration or initial referral for preschool special education services (children ages 3-5).

2. The school administrator and school nurse confer.

3. With the family, the school nurse initiates and completes an assessment of the student's health status and need for health services in school.

4. If the assessment indicates that the student may be eligible for special education, follow steps 2-12 in part D of this section.

5. The school nurse initiates development of an individualized health care plan (IHCP) in collaboration with the family, primary health care provider, medical specialists (when indicated) and student (when appropriate). The school administrator, school medical advisor and school nurse supervisor are consulted and informed, as appropriate.

6. Nursing assessment indicates that the student requires health services only.

7. The IHCP is finalized and preparations for student safety/care are completed immediately.

8. The student enters the regular classroom and receives health services as specified in the IHCP.

9. Other school personnel are provided appropriate information, if indicated.

10. The school nurse monitors the student's health status in school and maintains communication with the family and primary health care provider, as indicated.

11. The IHCP is reviewed whenever a change in health status occurs, or at specified intervals, and is revised accordingly **(repeat steps 2-9 above)**.

B. Prospective student with known special health care need that has risk of emergency/crisis or deterioration of health status in school and no known educational handicap; requires services or supervision by school personnel in addition to the school nurse.

Examples:

- Student with chronic illness requires daily gastrostomy feeding in school.
- Student with moderate, but controlled, asthma requires monitoring, medication and emergency planning.
- Student with behavioral problems requires collaborative interventions.

1. Prior to entry, the parent/guardian notifies the school administrator or school nurse that the student may require health services or monitoring in school. This should be done as early as possible, for example, at kindergarten registration or initial referral for preschool special education services.

2. The school administrator and school nurse confer. If the student has a special health care need related to mental health, the school mental health professional collaborates with the school nurse in the assessment and planning process.

3. With the family, the school nurse initiates and completes an assessment of the student's health status and the student's health and safety needs in school.

4. The school nurse initiates development of an IHCP in collaboration with the family, primary health care provider, medical specialists (when indicated), and student (when appropriate). The school administrator, school medical advisor and school nurse supervisor are consulted and informed, as appropriate.

5. If the assessment indicates that the student may be eligible for special education, follow steps 2-12 in part D of this section.

6. Nursing assessment indicates the student requires health-related services or supervision by school personnel in addition to the school nurse.

7. The school administrator and school nurse initiate a team meeting of appropriate school personnel, family members and community health care provider(s) to:

   (a) review the student's health service and safety needs;
   (b) assign responsibilities;
   (c) identify need for personnel training and supervision;
   (d) identify supplies, equipment and other preparations or adaptations necessary for the student's care and safety;
   (e) assign one school team member to act as the school liaison for the family; and
   (f) finalize the IHCP accordingly.

8. Preparations are completed for safe student entry.

9. The student enters the regular classroom and receives health services as specified in the IHCP.

10. Team members maintain regular communication about the student's health status and progress.

11. The school nurse monitors the student's health status, maintains communication with team members and the family, and provides services and/or supervision of other personnel in the delivery of health services as specified in the IHCP.

12. The IHCP is reviewed whenever a change in health status occurs, or at specified intervals, and is revised accordingly **(repeat steps 2-11 above)**.

C. **Student already in school with new or previously unidentified special health care need (regular education).**

Examples:

- 7th grade student newly diagnosed with diabetes mellitus.
- Student with situational crisis that requires short-term therapy and support, as well as monitoring, in school.

1. The school administrator and school nurse confer. If the student has a special health care need related to mental health, the school mental health professional collaborates with the school nurse in the assessment and planning process.

2. With the family, the school nurse initiates and completes an assessment of the student's health status and needs for health services in school.

3. The school nurse initiates development of an IHCP in collaboration with the family, primary health care provider, medical specialists (when indicated), and student (when appropriate). The school administrator, school medical advisor and school nursing supervisor are consulted and informed, as appropriate.

4. If the student's special health care need does not require services of school personnel other than the school nurse and the student has no known educational handicap, follow steps 6-9 in part A of this section.

5. If the student requires health-related services or supervision by school personnel other than the school nurse and the student has no known educational handicap, follow steps 6-11 in part B of this section.

6. If the assessment indicates that the student may be eligible for special education, follow steps 2-12 in part D of this section.

7. If, at any time, a student's health status changes or becomes unstable to the degree that it is unsafe for the student to remain in the classroom until the planning and preparation process is complete, it may be necessary to initiate proceedings for temporary homebound instruction (or instruction in a hospital setting) and referral for special education eligibility evaluation. The decision to place the child on temporary homebound instruction due to medical considerations is made by the family, health care provider(s), school nurse/nursing supervisor, school administrator and school medical advisor. In the event of disagreement between the school and family about placing the child in homebound instruction pending a medical review of the child's health status, either the parent or school may initiate due process regarding the child's program. Of course, emergency medical decisions remain the responsibility of the school health professional. The parent/guardian must always be informed of his/her rights to due process and should be assisted to exercise those rights as he/she chooses.

D. Prospective student with known special health care need and potential for educational handicap related to health care need.

Examples:

- Student with spina bifida.
- Student with pervasive developmental delay.
- Student with chronic illness that interferes with attendance and performance in class.
- Student with psychiatric disorder.
- Student with complex medical need.

1. Prior to entry, the parent/guardian notifies the school administrator or school nurse that the student may require health services and/or monitoring in school. This should be done as early as possible, for example, at kindergarten registration or referral for preschool special education.

2. The school administrator and school nurse confer; if the potential need for special education services is identified at this time, the normal process of referral and evaluation for eligibility and educational programming is initiated according to usual procedures.

3. As part of the evaluation process, or as the first step in the evaluation process, the school nurse, in collaboration with the family, initiates and completes an assessment of the student's health status and need for health services in school and collaborates with school mental health professionals, as appropriate.

4. The school nurse initiates development of an individualized health care plan (IHCP) in collaboration with the family, primary health care provider, medical specialists (when indicated) and student (when appropriate). The school administrator, school medical advisor, school nurse supervisor and other members of the PPT are consulted and informed, as appropriate. If the placement location of the student can be anticipated, initial preparations to ensure student safety in school can begin.

5. If the student is determined eligible for special education, and the educational handicap is related to the student's health impairment, the student's individualized health care plan (IHCP) is finalized through collaboration with the PPT and incorporated into the IEP. The following should be included:

   (a) specific educational goals and objectives;
   (b) services to be provided;
   (c) assignment of responsibilities for services;
   (d) determination of staff training needs;
   (e) plan of supervision for delegated responsibilities;
   (f) assignment of one school team member to act as the liaison with the family; and
   (g) dates for review of the student's progress and the IEP.

6. Preparations for safe entry are completed.

7. The student enters the regular or special education classroom and receives education and health services as specified in the student's IEP.

8. Team members maintain regular communication about the student's health status and progress.

9. The school nurse monitors the student's health status, maintains communication with team members and the family, and provides services and/or supervision of other personnel in the delivery of health services as specified in the IEP. Other members of the team maintain communications, provide services and/or supervision as specified in the IEP, and notify the school nurse whenever a change in the student's health status is noted or suspected.

10. The IHCP component of the IEP is reviewed whenever a change in the student's health status occurs. If such review indicates the need for change in the IEP, the PPT reconvenes (including the family, primary care provider, etc.) to make necessary IHCP/IEP changes. The PPT, family, primary care provider, etc. should collaborate on these revisions to the IHCP/IEP. In situations where changes in the student's health status can be anticipated, modifications or alterations that should be implemented when the anticipated change occurs should be incorporated into the initial IHCP/IEP in order to avoid unnecessary delay in the required alteration of school health services or program modifications.
11. Because changes in the student's health status cannot always be anticipated and planned for, a sudden change in the student's health status may require immediate changes in the IHCP portion of the IEP (such as what level of personnel can provide a specific service). Such changes may need to be implemented immediately based on the judgment of the health care professional(s) on site. Related changes in the IEP may then follow as quickly as the process can be initiated.

12. The student's IEP and special education eligibility are reviewed and re-evaluated in accordance with the process already set up for special education.

E. **Prospective student with known special health care need and potential for educational handicap; unrelated to need for special education program.**

Example:

- Student with learning disability also requires cast care for broken leg.

1. Prior to entry, the parent/guardian notifies the school administrator or school nurse that the student may require health services and/or monitoring in school. This should be done as early as possible, for example, at kindergarten registration or initial referral for preschool special education.

2. The school administrator and school nurse confer; if the potential need for special education services is identified at this time, the normal process of evaluation for eligibility and program needs is initiated according to usual procedures.

3. As part of the evaluation process, or as the first step in the evaluation process, the school nurse, in collaboration with the family, initiates and completes an assessment of the student's health status and the need for health services in school and collaborates with school mental health professionals, as appropriate.

4. The school nurse initiates development of an IHCP in collaboration with the family, primary health care provider, medical specialists (when indicated) and student, as appropriate. The school administrator, school medical advisor, school nurse supervisor and other members of the school team are consulted and advised, as appropriate.

5. At the PPT, the school nurse presents the health information obtained through the health assessment process that is relevant to the student's educational needs and program. All other PPT participants, including the family and student, present relevant evaluation data and the PPT decides whether the student is eligible for special education.

6. If the student is eligible for special education, but the student's health care needs are clearly not related to his/her educational handicap, then the IHCP is **not** incorporated into the IEP. The health care plan is then finalized as in part A (steps 7-11) of this section or in part B (steps 6-12) of this section, depending on the health services and/or monitoring needs of the student. The health care plan may be finalized at the same time as the PPT meeting (for convenience), but should involve only those personnel on the school team who are required for planning the health services.

7. If the student is not eligible for special education, the IHCP is finalized as in part A (steps 7-11) or part B (steps 6-12) of this section.

F. **Student currently eligible for special education with new or previously unidentified special health care needs.**

Examples:

- Special education student returning after automobile accident and hospitalization.
- Special education student returning from psychiatric or drug treatment facility.

1. The school nurse and school administrator confer.

2. With the family, the school nurse initiates and completes an assessment of the student's health status and need for health services in school and collaborates with school mental health professionals, as appropriate.

3. If the health care needs of the student are potentially related to the student's educational needs, the PPT should re-evaluate the student's program needs and follow steps 4-12 in part D of this section.

4. If the health care needs of the student are not related to the student's educational needs, the school nurse initiates development of an IHCP in collaboration with the family, primary health care provider, medical specialists (when indicated) and student (when appropriate). The school administrator, school medical advisor, school nurse supervisor and other members of the school team are consulted and advised, as appropriate.

5. If the student's health care needs do not require services of school personnel other than the school nurse, follow steps 6-9 in part A of this section.

6. If the student requires health-related services or supervision by school personnel other than the school nurse, follow steps 6-11 in part B of this section.

7. If, at any time, a student's health status changes or becomes unstable to the degree that it is unsafe for the student to remain in the classroom until the planning and preparation process is complete, it may be necessary to initiate proceedings for temporary homebound instruction while a PPT is arranged to review and revise the student's IEP, if appropriate. The decision to place the child on temporary homebound instruction due to medical considerations is made by the family, health care provider(s), school nurse/nursing supervisor, school administrator and school medical advisor. In the event of disagreement between the school and family about placing the child on homebound instruction pending a medical review of the child's health status, either the parent or school may initiate due process regarding the child's program. Of course, emergency medical decisions remain the responsibility of the school health professional. The parent/guardian must always be informed of his/her rights to due process and should be assisted to exercise those rights as he/she chooses.

PROGRAM MODIFICATIONS AND ENVIRONMENTAL ADAPTATIONS

In order for students with special health care needs to access appropriate educational programs, modifications of one or more aspects of the regular school program and adaptations in the environment may be necessary. These modifications should be determined by the school team, including the family, and based on an assessment of the child's needs, the school environment and available resources. The term "school team" refers to the PPT for a special education student and to a similar team of family and appropriate school professionals for a regular education student.

Because of their differences, students with special health care needs have a wide range and variety of actual and potential special needs in school. Many of the program modifications necessary to meet those needs are already well described or defined in other documents, guidelines and/or the law and will not be detailed in this document. Therefore, while this section will list many of the program modifications and environmental adaptations that may be appropriate for students with special health care needs, it will elaborate only on those modifications for which specific guidelines do not already exist or for which clarification seems appropriate.

The following outline of potential program modifications and environmental adaptations may serve as a guide in the process of assessing an individual student's needs, planning for a safe environment and implementing a student's individualized health care and/or educational program. It may also be used for review of general program considerations in planning for students with health impairments. A checklist for IHCP and IEP planning is included in Appendix J, Sample Forms.

1. **Health Assessment, Planning and Services/Interventions by the School Nurse**

   A. Health Assessment Components

      1. Current health status
      2. Developmental appraisal
      3. Medical diagnoses/treatments/orders
      4. Nursing diagnoses and collaborative health problems
      5. Routine and emergency health care needs
      6. Health procedures/equipment/supplies
      7. Environmental safety issues

   B. Individualized Health Care Plan (IHCP)

      1. Initial plan (prior to team meeting)
         a. Health problems/nursing diagnoses
         b. Student health goals
      2. Completed plan (during team meeting)
         a. Collaborative health problems and nursing diagnoses
         b. Student health goals
         c. Health interventions
         d. Responsible person(s)

e. Methods of evaluation and timelines
f. Identification of a school liaison (for the family)

3. Emergency care plan
   a. Potential emergency problems
   b. Student health goals
   c. Emergency health interventions and coordination with community emergency services
   d. Use of photo I.D., Medic Alert or other means to enable student to keep emergency information on his/her person at all times (as feasible and appropriate)
   e. Responsible person(s)
   f. Methods of evaluation

C. Other Nursing Services/Interventions

1. Health status monitoring/supervision/reassessment
2. Promotion of student independence in all aspects of health maintenance and activities of daily living
3. Health counseling and education
4. Health care procedures/treatments/medications
5. Personnel training
6. Personnel supervision
7. Coordination/collaboration with family
8. Coordination/collaboration with teachers and other pupil personnel specialists
9. Coordination/collaboration with health care providers and other community agencies
10. Consultation with school medical advisor
11. Referrals to health care providers and other pupil personnel specialists
12. Implementation of emergency care, as needed
13. Collaboration with and, as appropriate, on-site supervision of private duty nurse who accompanies a medically-complex student to school
14. Revision of health care and emergency care plans, as appropriate
15. Advocacy for student and family

II. Educational Assessment, Planning and Placement by the School Team

A. Educational Assessment

1. Parent and/or school concern
2. Multidisciplinary assessment
3. Health status
4. Developmental/behavioral status
5. Academic status
6. Psychosocial status
7. Family priorities
8. Individualized special needs: academic, environmental, related services, adaptive equipment

B. Educational Planning/Placement

1. Regular education with program modifications and/or support services.
   a. IHCP

b. The student's health and educational status should be monitored by one or more members of the school team

2. Special education with program modifications, special placement and/or related services
   a. Student goals
   b. Method of goal achievement
   c. Responsible personnel
   d. Methods of evaluation
3. Environmental adaptations
4. Family responsibilities
5. Funding

III. Instructional Program Modifications (as agreed upon by the family and school team)

A. Scheduling

1. Limited daily hours or limited days
2. Rest period in school
3. Accommodations for required health services (minimize time lost from instruction and maximize therapeutic effects of health interventions)
4. Flexible hours and schedule
5. Most challenging instruction when student least fatigued and/or when medication is most effective
6. Location of classes

B. Transition Planning

1. Birth-to-Three to preschool
2. Preschool to elementary
3. Primary to middle school
4. Middle to high school
5. High school to adult environments
6. Home/hospital based instruction to school
7. School to home/hospital-based instruction

C. Curriculum

1. Regular, modified regular or special program
2. Instructional aids
3. Behavior modification
4. Modification of materials
5. Modification of modes of instruction
6. Instructional and adaptive equipment
7. Accommodations for frequent absenteeism (e.g., extra set of books at home)
8. Accommodations for limited mobility (e.g., textbooks kept in each classroom, elevator pass, early/late passes, peer partner)
9. Timelines for completing assignments, tests and other tasks
10. Special personnel
11. Home-school log to accompany nonverbal student

D. Tutoring and Pre-Planned Home/Hospital-Based Instruction

1. Extra tutoring (regular or intermittent)
2. Immediate home-based instruction when absent (for chronically ill students who can be anticipated to have frequent school absences)
3. Concurrent school/home-based instruction
4. Immediate hospital-based instruction when hospitalized, condition permitting (for chronically ill students who can be anticipated to have hospitalizations)

E. Training and Supervision of School Personnel Regarding Health Needs and Health Procedures of Students

F. Preparation of and Support for Classmates

IV. Services Provided by Other Pupil Personnel Specialists

A. Social work
B. Counseling
C. Psychology
D. Speech and language
E. Physical therapy
F. Occupational therapy

V. Transportation

A. General Guidelines

1. Legal mandates in the State of Connecticut regarding student transportation, as of January, 1992, can be found in Appendix I, Transportation Information.
2. Transportation must be considered in planning for students with special health care needs.
3. Transportation is a related service for special education students.
4. Communication with transportation personnel is essential in the following situations:
   a. prior to the opening of school to share information about the students with special health needs who will be transported and their requirements for safe transportation;
   b. during team planning meetings or PPTs when transportation issues for individual students are discussed and plans are made (or prior to such meetings when the attendance of a transportation representative is not feasible); and
   c. on a regular basis for information sharing, collaborative planning and evaluation of transportation plans and services.
5. A standardized form that maintains appropriate confidentiality of the student and family should be used to communicate appropriate information with transportation personnel about a student's special needs during transportation. Emergency and/or more detailed medical data can be supplied in a sealed envelope for emergency personnel who arrive at the scene of an emergency (see Appendix J, Sample Forms).

6. Transportation personnel need general and child-specific training related to students with special health, safety and/or emergency needs during transportation.
7. Depending on the needs of students transported, general training of transportation personnel should include the following:

    a. safety requirements for special needs students;
    b. first aid/emergency recognition;
    c. emergency reporting with a two-way communication device;
    d. cardiopulmonary resuscitation (CPR);
    e. infection control;
    f. evacuation techniques for special students;
    g. behavior management;
    h. special communication techniques;
    i. confidentiality requirements;
    j. special transportation equipment; and
    k. route management and related issues.

8. Transportation personnel need regular supervision.
9. Transportation vehicles should have equipment and personnel necessary for evacuation of all students in the event of an emergency.
10. Transportation vehicles should carry appropriate emergency equipment, including the following:

    a. two-way communication device;
    b. belt cutter;
    c. fire blanket;
    d. first aid kit;
    e. CPR mouth protector; and
    f. infection control clean-up kit with —
        (1) latex gloves,
        (2) scoop,
        (3) disinfectant,
        (4) absorbent material, and
        (5) plastic bags and ties.

11. Vehicle evacuation drills should include **all** students. If any student is too fragile to participate in such a drill, the driver and/or attendant should practice the drill with a substitute student.

B. Transportation Personnel

1. **Driver**: The primary function of the driver is to safely transport all children in the vehicle to and from school. Therefore, while the driver should be prepared to handle a true emergency, he must never be utilized to provide routine or intermittent care to an individual student during actual transport. Any diversion of the driver's attention from his primary responsibility may be dangerous for all students in the vehicle.

2. **Transportation aides:**
   a. It is appropriate to use transportation aides when:
      (1) one or more students require assistance (not specialized health care) during transportation and the school team has determined that such assistance by an aide is appropriate;
      (2) one or more students require specialized health care on an emergency basis only and the school nurse determines that an aide can be taught the emergency intervention (this is reasonable even if the intervention is usually performed by licensed personnel since the student does not routinely require such care during transportation and the aide accompanies the student only to provide life-saving assistance in an anticipated, but rare emergency); or
      (3) the driver requires assistance to evacuate students from the vehicle in an emergency.
   b. Transportation aides should never be used to provide specialized health care to a student who requires such care during transportation on a regular or intermittent basis when it has been determined that such care (in school) should be provided by a licensed professional.
   c. Transportation aides must never be used to provide specialized health care to a student when the school nurse has determined that it is not safe to delegate the care to unlicensed personnel during transportation of the student.
   d. The need for a transportation aide is determined on a case-by-case basis taking into consideration the individual student's health care needs.

C. Vehicle

1. Students with special health care needs should be transported in the least restrictive and most appropriate vehicle.
2. Modes of transportation
   a. Regular route school bus
   b. Special school bus
   c. Van
   d. Car
   e. Mass transit (with aide)
   f. Ambulance
3. Choosing appropriate vehicles requires consideration of several factors:
   a. Seating and seat belts or other safety restraints;
   b. Securing of special seats, wheelchairs or gurneys;
   c. Special seating devices;
   d. Special equipment (e.g., oxygen, suction, wheelchair, car seat)—
      (1) location (especially chemicals) and
      (2) method of securing;
   e. Two-way communication device;
   f. Chemical safety/fire hazards (e.g., acid battery-powered wheelchairs, oxygen); and

g. Access to vehicle—
   (1) method of entering/exiting vehicle,
   (2) consideration of need for ramp/incline safety, and
   (3) parking spaces sufficiently wide.

VI. School Environment

A. School building: Exterior

1. Paths or walkways — width, inclines, interruptions
2. Playground — access and safety
3. School entrance/exit
   a. Access from vehicle
   b. Steps/ramps/handrails
   c. Door (swing vs. slide), door handle
   d. Assistance
   e. Emergency exits

B. School building: Interior

1. Hallways — width, corners, projections, ramps, handrails
2. Elevators — access, key, operation of buttons, assistance
3. Stairs and landings — handrails, non-slip grids
4. Windows — safety glass
5. Floors — non-slippery, clean, warm
6. Electrical sources — regular and emergency
7. Classrooms
   a. Access
   b. Exits for fire safety
   c. Space for maneuvering without hazards
   d. Transfer considerations — space, height of furniture
   e. Equipment
   f. Storage for equipment
   g. Electrical outlets
   h. Seating
   i. Lighting
   j. Chemical safety (e.g. oxygen use, equipment)
   k. Telephone
   l. Sink for routine handwashing and food preparation
   m. Separate sink for handwashing after toileting or diapering and cleaning soiled materials if carried out in classroom area
   n. Other infection control considerations
   o. Telephone with emergency line
   p. Other safety considerations
8. Health room
   a. Access
   b. Transfer considerations
   c. Furniture
   d. Sink(s)
   e. Privacy
   f. Space
   g. Storage
   h. Supplies and equipment
   i. Lavatory — wheelchair accessible

j. Telephone with emergency line
k. Other safety considerations

9. Lavatories, sinks, showers
   a. Access
   b. Height of sink/toilet
   c. Grab bars
   d. Transfer space
   e. Protection from hot water pipes
   f. Water control handles
   g. Shower seat
   h. Infection control
   i. Telephone with emergency line
   j. Other safety considerations

10. Other access/safety and infection control considerations
   a. Drinking fountains
   b. Switches, controls, fixtures
   c. Cafeteria
   d. Gym
   e. Lockers
   f. Other school rooms or facilities
   g. Back-up equipment

FUNDING ISSUES

A critical issue in providing education for students with complex health care needs is that of financial resources. Providing safe and appropriate health services for students with special needs can be very costly for school districts in terms of staff time, equipment, supplies and environmental safety. Family costs of caring for medically complex children at home are often both extraordinary and devastating. While issues regarding responsibility for funding of special health care services in schools are argued in the courts and efforts to find reasonable solutions to these problems continue, the following information may be helpful. These data, however, pertain to Connecticut at the end of 1991 and may rapidly change in accordance with new state or federal mandates and new decisions in case law.

Potential Reimbursement Sources for School Health Services

If nurses or other pupil personnel staff provide services to special education students as part of their special education programs, and if they spend more than one-third of their time providing services for such students, the school district can be reimbursed under C.G.S. Section 10-76f for such staff expenditures. Usually, but not always, a maximum of 85 percent of the staff member's full-time salary and benefits costs is reimbursable.

Public Acts 89-315 and 91-16 modified Section 10-76d of the C.G.S. to mandate school districts which have "more than 75 Medicaid-eligible" children to seek medical reimbursements for medically related services provided to special education students as part of these students' Individual Education Plans (IEPs). Such services include, but are not limited to, speech therapy, physical therapy and occupational therapy. While nursing services were not initially included in the list of health services that can be reimbursed through Connecticut Medicaid for eligible special education students, correction of this oversight is currently under consideration at the Department of Income Maintenance. In addition, school districts may receive Medicaid reimbursement for diagnostic evaluations provided to Medicaid-eligible children, whether or not those children are eventually determined to be eligible for special education services.

Another potential source of reimbursement for certain health screening, assessment, treatment and referral services provided by school nurses, nurse practitioners and physicians is the Health Track program for Medicaid-eligible children ages birth to 21. Health Track was previously referred to as Early Periodic Screening, Diagnosis and Treatment, or the EPSDT Program. In order to be eligible in Connecticut for reimbursement by the Department of Income Maintenance for Health Track services, however, a school must be licensed by the State Department of Health Services as a clinic, such as a school-based health clinic. This requirement varies from state to state. The Health Track program in Connecticut is administered through the Department of Income Maintenance.

Funding for Private Duty Nurses

When management of a student's medical condition requires constant care and monitoring by a licensed nurse (or at home, by a trained parent/guardian), a private duty nurse will need to accompany the student to school. Issues and pertinent court cases related to funding for such private duty nurses in the school setting are discussed in the Apgar article, Appendix K. For Medicaid-eligible students, the *Detsel v. Sullivan* case in New

York state {895 F.2d 58 (2d Cir. 1990) Court of Appeals} set a precedent which influenced at least one Connecticut case. Based on this precedent, the Connecticut Department of Income Maintenance, in 1990, began paying for a private duty nurse to accompany one student to school, although it is unclear whether this has any direct implications for future Connecticut cases.

Provision of Equipment

The family must provide that equipment which the student also needs at home for medical care, treatment or health care procedures due to his/her medical condition. This requirement is similar to the requisite that parents supply the medication for a student who needs to have medication administered in school. Examples of equipment are crutches, urinary catheters, respirators or oxygen tanks (for students who are known to require oxygen in school).

Equipment that must be provided by the school district is adaptive equipment necessary for learning or that is created for the educational process. Such equipment belongs to, and is retained by, the school district and can be used for other students, if appropriate, either concurrently or when the student no longer requires it for his/her educational program. Examples are: adaptive devices for improving performance of activities of daily living, for learning to read or write, positioning equipment required for optimal educational interaction, or FM trainers (auditory assistive systems).

Schools also should provide **emergency** equipment that is necessary to maintain life or to safely manage a medical crisis in the event that a student's own equipment malfunctions. For example, when students who require oxygen regularly or intermittently are in a school building, they must each supply their own oxygen equipment. In addition, however, the school should own and maintain one set of back-up oxygen equipment or equivalent, such as an Ambu Bag, to use in any emergency that requires the administration of oxygen.

Sometimes a student requires expensive medical equipment in school, but it is not feasible to transport the family's home equipment back and forth to school every day or for the family to purchase duplicate equipment. In this situation, it may be appropriate to creatively explore alternative resources in the community. At times, a business or civic organization in the community may be willing to donate such equipment. At other times, a PTA or other community group may be willing to raise funds in order to purchase the equipment.

Provision of Supplies

The parent is responsible for providing the special supplies required for health care procedures or other treatments that the student needs in school due to his/her medical condition. For example, such supplies may include diapers, special diets or formulas, sterile gloves for a procedure, and storage container, plus disinfectant, for a urinary catheter.

The school should provide those supplies that are required for routine school health services and back-up supplies that are necessary in the event of an emergency situation.

Supplemental Security Income (SSI)

New federal eligibility rules are enabling many more children and youth with disabilities from families with limited means to access supplemental income assistance

through SSI monthly payments. Based on the *Sullivan v. Zebley* case (U.S. Supreme Court, 1990), many children previously denied such assistance, including those with mental impairments, now qualify and may even be able to collect back benefits. Families with limited incomes and resources should contact their Social Security office for more information and to apply for benefits.

Once a family has applied for SSI benefits for a child, the Social Security Administration office will do a financial assessment. The application then goes to the Disability Determination Office (DDO) where an adjudicator determines if the child meets the medical requirements in terms of criteria for specific disease, mental retardation, or functional residual capacity. In Connecticut, children determined eligible for SSI assistance are not automatically eligible for Medicaid benefits as in many other states, but they can apply. If the DDO determines that a child with a disability is not eligible for assistance, it may be worthwhile for parents to reapply and to make sure that DDO has all of the medical records and physician information necessary. All applications for SSI are then sent to the State Department of Health Services, Children with Special Health Care Needs Program. Some children who are ineligible for SSI benefits may still be eligible for assistance through the Special Health Care Needs Program. (See Appendix M, Resources, State Department of Health Services).

Children with Special Health Care Needs

The Connecticut State Department of Health Services has Title V, Maternal and Child Health, federal funding to assist eligible children with special health care needs to receive appropriate health services, including diagnostic and therapeutic services, coordination of services and care management. See Appendix M, Resources, State Department of Health Services, for the appropriate telephone number and contact person.

Related Readings

1. Beckett, Julie. 1989. *Health care financing: A guide for families of children with special health care needs.* Iowa City: National Maternal and Child Health Resource Center. (College of Law Building, University of Iowa, Iowa City, Iowa 52242).

2. Lewin/ICF and Fox Health Policy Consultants. 1991. *Medicaid coverage of health-related services for children receiving special education: An examination of federal policies.* Washington, DC: U.S. Department of Health and Human Services. (For a copy, write to the Division of Health Financing Policy, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Room 442E, 200 Independence Avenue SW, Washington, DC, 20201, or call (202) 245-1870.).

3. McManus, M. 1988. *Understanding your health insurance options: A guide for families who have children with special health care needs.* Beth Seda: Association for the Care of Children's Health. (7910 Woodmont Avenue, Suite 300, Bethesda, MD 20814)

4. New England Serve. 1991. *Ensuring access: Family centered health care financing systems for children with special health needs.* Boston: Author.

5. New England Serve. 1990. *Primer on health insurance.* Boston: Author. (101 Tremont Street, Suite 802, Boston, MA 02108).

Events over the past ten years have shown that communicable diseases are far from extinct. The identification and ultimate spread of acquired immune deficiency syndrome (AIDS) continues unchecked, measles is again epidemic, and serious complications from streptococcal infections have returned. Schools have traditionally dealt with communicable diseases through (1) enforcement of immunization mandates and (2) exclusion of affected students. School policies have enforced the requirement for mandatory immunizations prior to school entry for vaccine preventable contagious diseases such as measles, polio, and rubella. Additionally, students manifesting signs or symptoms of acute infectious diseases, such as influenzae, impetigo, ringworm or chickenpox, have been excluded from school for the duration of the illness. These acute infectious diseases have usually been either self-limiting or perceived as "curable" with a medication, such as an antibiotic. As a result, public awareness of the importance of prevention diminished. Furthermore, traditional school policies related to infectious diseases were based on the comparatively short period of communicability of acute infections. Therefore, limited exclusion from school attendance and restrictions on return to the classroom were generally accepted practices.

The advent of AIDS in adults and school-age children in the early 1980's produced an awareness among the general public that individuals do not always have signs or symptoms of illness that indicate the presence of an infectious organism. Many infectious organisms can exist in a host for brief or extended periods while the individual appears and feels healthy. Advances in medical technology now document the existence of such organisms in blood, other body fluids or tissues and molecular biology studies are providing an understanding of the interrelated events of infection, susceptibility, and immunity.

In 1985, the Connecticut State Departments of Education and Health Services published guidelines entitled, *Prevention of Disease Transmission in Schools: AIDS*, to address issues related to infection control in schools. That document was initiated when school administrators, teachers and parents expressed concern about the school admission of students with AIDS, currently referred to as human immunodeficiency virus (HIV) infection. An adaptation from these Guidelines entitled *Guidelines for Handling Body Fluids in Schools* is included in Appendix G. A model policy for local boards of education, *Educating Students with Chronic Infectious Diseases*, Appendix H, has been developed for admission of students with HIV infection or other chronic viral infections, including cytomegalovirus (CMV), hepatitis B virus (HBV) and herpes.

The Process of Infection

An infectious disease may be endemic (a constant presence of the infectious agent in a geographic area or the general prevalence of a given disease) or epidemic (an increase in the number of cases in excess of expectancy). In order to understand the fundamentals of infection control, one must understand the process of infection. See the diagram PROGRESSION OF INFECTION on the next page.

IA = Infectious Agent

PROGRESSION OF INFECTION

HOST

PERSON, ANIMAL, BIRD OR INSECT

PRIMARY (RESERVOIR)
IA lives, develops and multiplies

TRANSPORT
Carrier of live IA and no development

TRANSMISSION MODE

DIRECT

Immediate entry of IA into other person from host

OR

INDIRECT

1. Person uses object contaminated by host, entry usually from hand to mouth
2. Insects move IA from host or act as a primary host for IA

OR

AIRBORNE

IA suspended in air for long periods of time; entry usually through respiratory tract

SUSCEPTIBLE PERSON

One who has inadequate resistance to prevent contracting infection or disease

OR

RESISTANT PERSON

One whose body has the ability to prevent the development or multiplication of an IA; ability may be genetic or acquired, permanent or temporary

OR

IMMUNE PERSON

One who has protective antibodies against an IA to prevent infection or illness if exposed; may be overwhelmed by exposure to a large dose of IA, or by concurrent illness

Each infectious disease is caused by a specific pathogen (infectious agent). The causative pathogens for most infectious diseases have been identified using sophisticated laboratory equipment. These pathogens or infectious agents are:

- microscopic in size (unable to be seen without magnification);
- classified by their characteristics, such as virus, bacteria, toxin, yeast, parasite; and
- potentially capable of producing infection.

Humans become the unwitting host or reservoir for most of the organisms that create infectious diseases in humans. Animals, insects and plants are less common hosts of such infectious agents.

In order for transmission of an infectious disease to occur, the specific infectious agent must:

- leave the host;
- be carried to a new susceptible host; and
- gain entry into the new host.

Body excretions, such as saliva, urine and feces, are common transmitters of influenza, CMV, and salmonella, respectively. Blood, which is normally sterile, is considered the main source of HIV and HBV transmission. Therefore, any body excretion containing even minute amounts of blood should be handled with precautions. Furthermore, one cannot rely on individuals infected with an organism to show signs or experience symptoms of infection. For example, a susceptible person may be incubating the organism before becoming ill or a person with resistance or immunity to the organism may still be a carrier and, therefore, a source of transmission to others. As a result, universal precautions and general infection control precautions should be used routinely (always) in keeping with the guidelines described below.

Universal Precautions

Universal precautions are intended to prevent occupational exposure to a **bloodborne infectious agent** through contact with blood and other potentially infectious materials. Since blood is the single most important source of a bloodborne infectious agent (such as HIV or HBV) in the occupational setting, one should assume that all blood, or body fluids containing visible blood, may carry an infectious agent. Universal precautions also apply to semen and vaginal secretions and non-excretory body fluids, such as cerebrospinal fluid, but these are not considered a source of transmission in the school setting.

Universal precautions require that gloves be used for touching blood, or body fluids that contain visible blood, whenever possible. Gowns or protective clothing should be used if soiling of clothing with blood or blood-containing body fluids is likely. Protective eyewear or face shields may be needed when there is risk of splattering or splashing blood or body fluids containing blood into the eyes, mouth or nose during certain procedures.

Disposable gloves (nonsterile or sterile), either latex or vinyl, provide barrier protection for both the student and the hands of the caregiver during performance of tasks when contact with blood, or body fluids with visible blood, is likely. These gloves must never be washed or cleaned with the intent to reuse. Soaps and disinfectants can cause deterioration or increase permeability of disposable gloves. Clean disposable

gloves must be used for each task, removed as soon as the task is completed and disposed of appropriately. This activity should be immediately followed by routine handwashing.

General purpose utility gloves (rubber gloves) for housekeeping chores which involve potential contact with blood or body fluids may be decontaminated after contact and re-used but should be discarded if there are any signs of deterioration such as: holes, peeling, cracking, or discoloration.

Universal precautions do not apply to saliva. General infection control practices do recommend the use of gloves for examination of mucous membranes, endotracheal suctioning or when the caregiver's hand(s) must enter a student's mouth to perform a specific treatment. Gloves need not be worn when feeding or wiping saliva or nasal discharge from the skin with a tissue.

Universal precautions do not apply to urine, feces, nasal secretions, sputum, sweat, tears, or vomitus unless visible blood is present. However, general infection control practices (for the prevention of transmission of other types of infectious agents) do recommend the use of gloves when diapering, assisting with toileting, changing a dressing on a draining wound, or cleaning soiled articles or clothing.

General Principles of Infection Control

In addition to establishing policy and procedures for appropriate and consistent utilization of universal precautions, schools must develop and establish similar procedures for routine infection control. Infection control procedures diminish the spread of those communicable diseases most frequently disseminated in schools. Rather than transmission through contact with blood, these communicable diseases are transmitted through contact with other body fluids, most frequently respiratory secretions and stool. Examples are the common cold, other respiratory viruses, gastrointestinal viruses, influenza (flu), chickenpox, measles, fifth disease, and streptoccocal or other bacterial infections, including tuberculosis. Therefore, principles of infection control must be incorporated into district policy and procedures.

1. Hands must be washed:

   - **after** personal/close contact with an individual or with contaminated articles;
   - **before** taking care of others or performing other tasks/activities;
   - **before** eating (or putting hands in mouth);
   - **after** toileting; and
   - **after** using gloves.

2. The **routine use of recommended standards** should be established for:

   - cleaning (removal of infectious agents by scrubbing and washing to decrease the survival or multiplication of microorganisms);
   - disinfection (killing of infectious agents outside the body);
   - sterilization of special equipment and articles used by or for students;
   - personal protective equipment when appropriate; and
   - housekeeping of the environment.

Infection Control for Schools

Prevention of the spread of infectious diseases in schools or classrooms begins with a review of current infection control or hygienic practices and health education programs. This includes review of institutional or environmental protocols. For example, separate sinks should be assigned for (1) handwashing after toileting or diapering a student and (2) food preparation or dishwashing. Equally important are individual or personal hygiene practices (protective measures within the responsibility of the individual) which promote health and limit the spread of infectious diseases.

Through its infection control program, a school district must do the following:

1. Enforce compliance with mandated Immunizations (C.G.S. Sec. 10-204a) and health assessments (C.G.S. Sec. 10-206) and include screening for tuberculosis prior to enrollment of **all** students.

2. Exclude/admit an employee or student with an infectious disease according to public health codes (C.G.S. Sec.19a-36) and policy set by the school medical advisor (appointed under C.G.S. Sec.10-205 and duties outlined in C.G.S. 10-207).

3. Establish a written Exposure Control Plan (29 CFR Part 1910-1030) for implementation of procedures relating to the control of infectious disease hazards in the worksite according to current requirements of the Occupational Safety and Health Administration (OSHA), U.S. Department of Labor. OSHA Regulations regarding Occupational Exposure To Bloodborne Pathogens were published Friday, December 6, 1991, in the Federal Register, Vol. 56, No. 235. These regulations must be followed in developing a school "Exposure Control Plan." Some of the components of such a plan include, but are not limited to:

    - universal precautions in which all human blood and other potentially infectious materials are treated as if known to be infectious for HIV and HBV;
    - engineering controls that use available technology and devices to isolate or remove hazards from the worker and students (for example: puncture-resistant sharps containers);
    - work practice controls that alter the manner in which a task is performed in an effort to reduce the likelihood of an exposure to blood or other potentially infectious materials (for example: hand washing after removal of gloves);
    - provision of personal protective equipment such as specialized clothing or equipment used by staff to protect themselves from direct exposure to blood or other potentially infectious materials (for example: protective eye wear and face mask for endotracheal suctioning);
    - control of infectious wastes, including collection, storage and disposal of materials (for example: biohazard sign on containers);
    - housekeeping practices that assure that the schools are maintained in a clean and sanitary condition (for example: daily scrubbing of floor mats); and
    - recordkeeping of all incidences of potential/actual exposure of students or staff to infectious materials.

4. Offer and provide HBV vaccine to all employees who have occupational exposure to blood. Employees must sign a declination form if they choose not be be vaccinated, but may later opt to receive the vaccine at no cost to the employee.

5. Establish a program for staff education regarding infection control in schools. This program must include as a minimum:

   - initial orientation and continuing education of **all** employees regarding (1) the prevention of transmission of HIV and HBV and other infections; and (2) the need for routine use of universal precautions and infection control methods;
   - specific training in the proper technique of using personal protective equipment, e.g., gloves, and using approved disinfection and disposal methods of contaminated items for those employees who are actually or potentially exposed to blood and /or body fluids;
   - information on the HBV vaccine, including its efficacy, safety, and the benefits of being vaccinated, including offering free HBV vaccination for those at risk for direct contact with blood or infectious body fluids during the workday;
   - explanation of the procedure to follow if an exposure incident occurs, method of reporting the incident and medical follow-up that will be made available;
   - monitoring of employee adherence to recommended protective measures; and
   - employee assistance including counseling, additional education and training, and disciplinary action for failure to follow recommended precautions (practices).

Waste Management

School policies for defining, collecting, storing, decontaminating and disposing of potentially infectious waste materials should be in accord with state and local regulations. State Regulations of the Connecticut Department of Environmental Protection, Sections 22a-209-1 through -15 define biomedical waste as "untreated solid waste, any disposable container thereof and any reusable container thereof which has not been decontaminated, generated during the administration of medical care or the performance of medical research involving humans, animals, including infectious waste, pathological waste and chemotherapy waste." Schools usually generate a small quantity (less than 50 pounds in any calendar month) of such biomedical wastes while providing health care or health services. These wastes may include disposable syringes and needles used in administering medications, supplies used for blood tests, soiled dressings or bandages, discarded vaccine vials and other waste materials generated during science laboratory experiments, including culture dishes, pipettes, and microscope slides.

Schools that generate any of the above materials should have a **written biomedical waste management plan** with policies and procedures which assure that such items do not become integrated into regular waste for removal by trash collectors. Minimum standards for segregation from other wastes require biomedical wastes to be placed or collected in primary containers of (1) **sharps**, items capable of causing a puncture or cut, including broken glassware known to be contaminated with an infectious agent, (2) **blood or regulated body fluids** of 20 cc or greater, and (3) **other**.

Proper packaging requires that: (1) the above categories are not mixed in any one container; (2) all primary containers are rigid, leak-resistant, impervious to moisture, sufficiently strong to prevent tearing or bursting and sealed to prevent leakage; (3) sharps containers are puncture-resistant; and (4) fluids are placed in break-resistant containers that can be fit with a tight (leakproof) stopper or lid.

Each primary container must be labeled with at least a 3" by 5" water-resistant identification tag which indicates in indelible writing the name, address, and business location of the generator of the biomedical wastes. The labeled primary containers must be placed in a secondary container for storage (temporary holding), for transfer (move from one location to another on-site location) or for transport (move from the site for treatment, disposal, or further storage).

The secondary container may include different types of primary containers and must be similarly labeled to identify the generator and the transporter for mandated documentation of tracking of the disposal of such wastes. Before transport, the outside of each primary and secondary container must display the universal biohazard symbol or the words "medical waste" or "infectious waste".

All generators of biomedical wastes are responsible for maintaining documentation that the wastes are being disposed of properly. Special "tracking forms" or logs are used to document every step in the process and must be maintained for three years. Biomedical waste transporters and solid waste facilities are regulated by the EPA. A list of licensed Connecticut operators may be obtained from the Department of Environmental Protection at 566-5847.

Conclusion

In summary, handwashing continues to be the single most effective method of **self-protection** from infectious organisms and of **preventing transportation** of such organisms from one individual to another susceptible person. The first criteria for reducing the spread of infectious agents in schools is the general availability of sinks with warm running water plus soap and paper towels for use by staff and students. The next most important factor is the teaching and establishment of good handwashing habits at such times as: (1) before eating snacks or lunch, (2) after toileting, (3) after removing protective gloves and (4) before and after providing first aid or care to a student when contact is made with any body fluid, including saliva. The details for Handwashing and Use of Gloves are found in Appendix F. Additionally, in the Specialized Health Care Procedure Manual for School Nurses (to be published later this year) there are specific infection control measures included in the Steps and Notes of many of the procedures.

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SELF-EVALUATION TOOL: STANDARDS FOR SCHOOL HEALTH SERVICES AND PROFESSIONAL AND TEAM CHARACTERISTICS

The following self-evaluation tool has been adapted with permission from the document *Enhancing Quality: Standards and Indicators of Quality Care for Children with Special Health Care Needs*, published by New England Serve in 1989. The original document identifies key elements contributing to quality health care for children with chronic illness or disability and their families according to five aspects of the health care delivery system: Individualized Services, Health Professional and Team Characteristics, Health Care Agency or Facility Responsibilities, State Health Department Responsibilities and Guidelines for Community and Societal Supports.

This instrument is based on the first two sections of that document: Section I, Individualized Services; and Section II, Health Professional and Team Characteristics. It is intended to provide school staff members with a tool that can be used to evaluate certain aspects of their health services program and characteristics of their school team as they relate to serving students with special health care needs. Each standard is followed by several indicators of the standard. These indicators may or may not be relevant in a given instance and each school or school district may want to add other indicators that better reflect the standard in its setting. Accordingly, space for another indicator is provided under each standard.

For many school districts, the tool will be useful in reviewing and revising segments of school policies and procedures related to the population of students that have health-related disabilities or special health care needs in school. Specific standards and indicators can be incorporated into revised policies and procedures for regular education, special education, preschool and birth-to-three programs. The standards and indicators can also be utilized to some degree in developing performance evaluation criteria for school personnel who work with students with special health care needs. Use of this tool for self-evaluation purposes can promote open dialogue about school or team strengths and weaknesses and enhance collaboration among school team members. Finally, the tool can be used to obtain crucial feedback from parents and students regarding their perceptions of health-related school services.

Although the third section of *Enhancing Quality*, Health Care Agency or Facility Responsibilities, was not adapted for use in these Guidelines, it may be a useful reference for schools when evaluating policies that relate to serving students with special health care needs. Whatever the application, it is hoped that use of this self-evaluation tool will serve to enhance the quality of school services provided for students with special health care needs and their families.

I. INDIVIDUALIZED SERVICES

CHILD AND FAMILY PARTICIPATION

1.0 The student has representation through family membership on the school team.

- ❑ 1.1 Family members participate in team decision making regarding school health services, the development of the student's Individualized Health Care Plan (IHCP) and the development of the Individualized Education Plan (IEP), if eligible.
- ❑ 1.2 Expectations and roles of all team members are defined.
- ❑ 1.3 The family provides information regarding the student's strengths, needs and culture, as well as feedback regarding the services received.
- ❑ 1.4 Interpreter services are available.
- ❑ 1.5 The family is present at all Planning and Placement Team (PPT), and other planning team, meetings.
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2.0 Families provide informed consent for all specialized health services and special education programs based on information regarding benefits, risks and alternative procedures or services.

- ❑ 2.1 The student is included in the process of obtaining informed consent as he/she matures.
- ❑ 2.2 When service or program benefits remain unproven, as in innovative or research procedures, the implications of the service or program are fully explained.
- ❑ 2.3 Families are informed if significant disagreements occur among health and education professionals regarding the IHCP and/or the IEP and understand their option to seek additional opinions.
- ❑ 2.4 A process exists for resolution of conflict among health and education professionals and/or the family when there are differing opinions as to the appropriateness of services or programs.

- ❑ 2.5 Families are informed of the legal limits and requirements for parents and professionals in decision making regarding the student's health care in school.

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3.0 The student/family has access to the health care record.

- ❑ 3.1 Families receive written information regarding school health record-keeping policies and procedures, and their rights to full access to school health records to the extent provided by law regarding minor's rights.

- ❑ 3.2 Copies of information from the school health record and explanations regarding the content of the health record are provided to the family and/or student upon request, as appropriate.

- ❑ 3.3 Families have the opportunity to enter written comments in the school health record.

- ❑ 3.4 Family consent is obtained when written information from the school health record is shared with personnel other than members of the school health team.

- ❑ 3.5 Families are encouraged and assisted to establish a portable record-keeping system in order to maintain and use information from the school nurse and community health care providers.

- ❑ 3.6 The family provides the school with written consent for the school nurse to share information from the school health and nursing records with the student's community health care providers.

- ❑ 3.7 Adolescent students receive written information about their rights to confidentiality regarding specific health issues covered by law.

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4.0 The student and family receive a copy and/or a summary of the student's school health record upon request.

- ❑ 4.1 The summary includes, at a minimum, current nursing problems and diagnoses, physician's orders, the student's IHCP and guidelines for managing specific health crises in school.
- ❑ 4.2 Families receive assistance in translating the health record or summary into their primary language.
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5.0 A comprehensive assessment process precedes and guides the development of the individualized health care plan (IHCP).

- ❑ 5.1 The family participates in the assessment process.
- ❑ 5.2 Student and family reports of past and current needs form the basis of the assessment process.
- ❑ 5.3 The assessment process is comprehensive and includes health and other disciplines, as appropriate.
- ❑ 5.4 Determination of the health status and health care needs of a student is made by the school nurse and family in consultation with the school medical advisor, community health care providers and other members of the school team, as appropriate.
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6.0 Information concerning school health services, education adaptations, special education programs and available resources is shared among all members of the school team, including the family and health professionals.

- ❑ 6.1 Families receive appropriate educational materials concerning the student's specific educational disability, individual growth and development, injury prevention and related topics.
- ❑ 6.2 Information and guidance regarding the potential impact of the child's health status on his educational program and progress are provided.

- ❑ 6.3 Educational materials related to school health services are reviewed by an advisory group of parents for accuracy and relevance.
- ❑ 6.4 The school health team provides individual families with information on how to obtain a wide range of services including education, social, mental health, and self-help services and family support groups, as needed.
- ❑ 6.5 The family has access to written guidelines or standards of care that are applicable to school health and special education services for their child.
- ❑ 6.6 Materials for families are written in the primary languages of the major population groups served.
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7.0 Each student has a written individualized health care plan (IHCP) that guides all school health interventions.

- ❑ 7.1 The IHCP identifies one member of the school team to be a liaison with the family to ensure school-home-community coordination.
- ❑ 7.2 Students and families are assisted in understanding the implications of all services and procedures contained in the IHCP.
- ❑ 7.3 The IHCP is evaluated every three months or more frequently as required by the child's health status and needs.
- ❑ 7.4 The IHCP contains up-to-date information on service needs, resources to be used and designated professionals and paraprofessionals who are responsible for providing health services and/or supervising others who provide such services in school settings.
- ❑ 7.5 Community-based health professionals (e.g. primary care pediatricians, hospital-based personnel, home care professionals) participate in the development of the IHCP, as appropriate.
- ❑ 7.6 The IHCP includes health and other related services necessary to support the growth, development, education and career potential of each student regardless of his or her disability or illness.

- ❑ 7.7 The IHCP of a special education student is incorporated into the student's IEP whenever the student's health care needs are related to his/her education disability.
- ❑ 7.8 The family's culture and/or religion is considered in the development and implementation of the student's IHCP.
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8.0 School health services and specialized health care procedures in school are designed to recognize the strengths and needs of the student and family.

- ❑ 8.1 Family strengths, including cultural and ethnic identity, are respected and utilized in the delivery of school health services.
- ❑ 8.2 Health and education services are coordinated among school personnel in order to minimize interruption of the student's education program.
- ❑ 8.3 School health services, whenever feasible, accommodate family life activities.
- ❑ 8.4 The unique contributions and needs of brothers and sisters are identified and utilized in planning services and programs for the student and siblings in school.
- ❑ 8.5 Ongoing training regarding health procedures and the use and maintenance of specialized equipment is available to school health personnel and the student.
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9.0 The student's developmental level is considered in the delivery of school health services.

- ❑ 9.1 Developmental issues (e.g., need for mastery, dependence versus independence, sexuality education) are considered in developing the IHCP, providing school health services and/or making referrals to other community services.

- ❑ 9.2 School support groups and/or counseling available to students and adolescents are developmentally appropriate.
- ❑ 9.3 When feasible, students have opportunities to meet other young people with similar special health care needs.
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10.0 Continuity of care is maintained despite changes in the student's education setting, school personnel, or health care providers.

- ❑ 10.1 Comprehensive planning is provided for all transitions, such as school-to-hospital, hospital-to-home, home-to-school and early childhood-to-school.
- ❑ 10.2 Planning ensures linkage with education, health and community resources.
- ❑ 10.3 Transition planning occurs as the adolescent student moves from school towards adult community services.
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11.0 When the student's impairment or progression of his/her illness is irreversible, both student and family members receive support in coping with the condition.

- ❑ 11.1 The design of school health services prevents isolation of the student and family.
- ❑ 11.2 When death is the anticipated outcome, the student and family are supported and/or assisted in preparing for this eventuality both in school and through referral to family support groups and other community services.

- ❑ 11.3 Appropriate support services are provided to other students, the family and school staff members after the death of a student.
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ACCESSIBILITY OF APPROPRIATE SCHOOL HEALTH SERVICES

12.0 Services included in the Individualized Health Care Plan (IHCP) are delivered by personnel qualified to provide the services.

- ❑ 12.1 Qualifications of school health personnel are clearly communicated to families.
- ❑ 12.2 School health personnel and others performing health-related tasks receive appropriate clinical supervision.
- ❑ 12.3 Unlicensed personnel are properly trained and supervised by licensed personnel when providing health care services to students.
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13.0 The family receives full written information regarding health services offered by the local school district.

- ❑ 13.1 School health services program information and guidelines for accessing these services are clearly stated.
- ❑ 13.2 A schedule of school nurse hours in the building is provided.
- ❑ 13.3 A plan to provide safe first aid, emergency services and necessary health care services during hours when the school nurse is not in the building is provided.
- ❑ 13.4 Information on processes for appeal of an approved IHCP is provided.
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14.0 Financial implications of the IHCP are addressed.

- ❑ 14.1 The school's and the family's financial responsibilities for implementation of the IHCP (e.g. provision of special equipment, supplies or personnel) are clearly delineated during the planning process.
- ❑ 14.2 Families are referred to appropriate resources for assistance with financial management, insurance benefits, entitlement programs or access to other resources.
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II. SCHOOL HEALTH PROFESSIONAL AND TEAM CHARACTERISTICS

EDUCATION AND TRAINING

15.0 School health professionals have the specialized education, experience and credentials to deliver quality care.

- ❑ 15.1 The qualifications of school health professionals meet existing standards in the specific specialty area (e.g. licensure, education, certification, experience and recommendations).
- ❑ 15.2 School health professionals have specific education and experience regarding child and adolescent health and developmental issues.
- ❑ 15.3 The school health team is familiar with the culture of the child and family.
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16.0 Health care professionals maintain current knowledge and specialized training in order to deliver quality care.

- ❑ 16.1 School health professionals are knowledgeable about standards of care designed specifically for children with special health care needs and their families.

- ❑ 16.2 School health personnel participate in continuing education programs specific to health problems, services and issues for children and families.
- ❑ 16.3 School health professionals utilize up-to-date educational materials and obtain specialized training and education regarding specific illnesses and disabilities and/or related treatment modalities and intervention techniques.
- ❑ 16.4 The school administration supports appropriate continuing education for school health professionals in their area of clinical expertise through financial support and release time.
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THE ROLE AND FUNCTION OF THE SCHOOL HEALTH TEAM

17.0 The school health team consists of family members and those professionals who serve the student and family.

- ❑ 17.1 Construction of the school health team for an individual student will depend on the needs of the student.
- ❑ 17.2 Professional team members may have expertise in areas such as: education, special education, school administration, medicine, guidance, nursing, nutrition, occupational therapy, physical therapy, psychology, social work, and speech and language therapy.
- ❑ 17.3 Team members may include staff from community-based agencies when they are providing direct services to the student, such as an audiologist, primary care provider or behavioral pediatrician.
- ❑ 17.4 When staff turnover occurs, a designated team member assumes responsibility for informing the family and orienting new members to the team.
- ❑ 17.5 Interpreters are available at team meetings to ensure language translation and cross-cultural communication.
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18.0 A primary function of the school health team is to develop and implement an individualized health care plan (IHCP) for each student who has special health care needs in school.

- ❑ 18.1 The team meets to develop, coordinate and evaluate a plan of care.
- ❑ 18.2 A process is established to ensure communication among team members such as periodic meetings, telephone conferences, and/or sharing of written progress notes.
- ❑ 18.3 Family contributions and priorities are included in the development of the IHCP.
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19.0 A member of the school health service team is designated to coordinate school health services for each student.

- ❑ 19.1 The school health professional facilitates ongoing communication among community health care providers, other school team members, other agencies and the family.
- ❑ 19.2 The school health professional promotes consistent health care planning and service delivery among school personnel, community providers and family.
- ❑ 19.3 The school health professional assists the family to identify and utilize appropriate school and community resources.
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20.0 Coordination occurs to ensure smooth integration of the student into education settings.

- ❑ 20.1 A health assessment is completed by the school nurse on or before school entry of a student with special health care needs.
- ❑ 20.2 Necessary **training or assistance** is provided to designated school personnel to facilitate the student's safe integration into the school setting.

- ❑ 20.3 When a special education student's health impairment is related to his/her educational disability, the IHCP is finalized through the PPT process and is incorporated into the IEP.
- ❑ 20.4 A liaison for the family is assigned from the school team.
- ❑ 20.5 Special attention is given to **coordinating services** at times of transition into, within and out of education settings.
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21.0 School health professionals cooperate with primary health care providers and specialists in the community to ensure coordinated care.

- ❑ 21.1 School health professionals participate in collaborative health care planning and/or evaluation meetings with hospital, community health, home care and other health service providers.
- ❑ 21.2 School health professionals maintain appropriate communications with primary health care providers and specialists in the community to ensure continuity and timely alterations in care based on changes in the student's health status.
- ❑ 21.3 Referrals to community health care providers are coordinated through the school nurse.
- ❑ 21.4 Primary health care providers and specialists in the community participate in planning and evaluation meetings of the school team as much as feasible.
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RESPONSIVENESS TO SPECIALIZED NEEDS OF STUDENT AND FAMILY

22.0 The student's school health services are based on accepted standards and guidelines for practice.

- ❑ 22.1 School health services are provided according to the *Guidelines for Serving Students with Special Health Care Needs* established by the State Department of Education.

- ❑ 22.2 School services provided by health care professionals meet accepted guidelines for practice as defined by the professional boards and national organizations of those professions.
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23.0 School health service professionals obtain and utilize information about the student's developmental level in their delivery of care.

- ❑ 23.1 The school team obtains information from the family regarding the student's growth and development.
- ❑ 23.2 The school team obtains consultation or makes referrals for developmental evaluations.
- ❑ 23.3 Services and/or intervention and treatment protocols are designed to meet the developmental and age-appropriate needs of the student.
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24.0 School health professionals inform families of available resources.

- ❑ 24.1 Referrals are made to community agencies such as recreation, vocational assistance, mental health and creative arts.
- ❑ 24.2 Information is provided on parent-to-parent and other support services, including diagnostic-specific groups.
- ❑ 24.3 Families are encouraged to identify informal networks, (e.g., grandparents, neighbors, friends) and utilize them for support.
- ❑ _____

  _____

25.0 School health records are maintained for each student and are made available to the family.

- ❑ 25.1 The records include the individualized health care plan and documentation of all delivery of care.
- ❑ 25.2 The health care record documents training received by the student and family in health care procedures.
- ❑ 25.3 The health care record documents training and supervision of school personnel by school health professionals and/or community experts.
- ❑ 25.4 Summaries of team communication and conferences are included in the health care record.
- ❑ 25.5 Translation services are available to families.
- ❑ 25.6 Upon request of the family, a health care professional explains the contents of the student's school health records.
- ❑ 25.7 Records are legible and easily used.
- ❑ _____

  _____

26.0 Recognition is given to cost in the delivery of services.

- ❑ 26.1 The school team, family and community health care providers review appropriateness of school interventions and eliminate duplication of services.
- ❑ 26.2 The school team considers cost for families, the community and payors in selecting services, resources and equipment.
- ❑ _____

  _____

Adapted with permission from: New England Serve (1989). *Enhancing Quality: Standards and Indicators of Quality Care for Children with Special Health Care Needs.* Boston, MA.

SPECIALIZED HEALTH CARE ACTIVITIES

This section provides school administrators and school health professionals with overview information critical to the planning and implementation of 53 specialized health care activities for students. These overviews primarily address health care activities that are within the scope of nursing practice, but do not include all activities and/or licensed functions of nurses. Some of these health care activities are also within the scope of practice of other school health professionals, including speech-language pathologists and physical and occupational therapists. In addition to the overviews contained in this section, the Connecticut Department of Education plans to publish in 1992 a *Specialized Health Care Procedure Manual for School Nurses* with specific guidelines and resources for each of the 53 specialized health care activities.

For each health care activity, a box highlights critical information for school health professionals and school administrators to consider in planning for an individual student who needs that specialized health care in school. In order to understand the intent of this boxed information and how it should be used, carefully study the definitions and explanations following this introduction before attempting to use these guidelines. **Failure to do so may result in improper interpretation of the information and unnecessary problems in planning and implementing specialized health care in the school setting.**

In general, these specialized health care activities should be implemented for an individual child after:

- the school nurse has completed a health assessment of the child;
- the parent's permission and physician's orders (when applicable) are in writing in the student's health record;
- the school nurse and/or therapist (as appropriate) has adapted the procedure to the individual needs and preferences of the child and family;
- the school nurse, in collaboration with parents and other members of the school team (as appropriate), has developed an Individualized Health Care Plan;
- personnel have been sufficiently trained;
- a plan for supervision is developed and documented (when a procedure is delegated); and
- criteria and timelines for evaluation of the plan are established (for medically complex students, evaluation should be completed at least every three months).

Each student must be assessed individually by the school nurse before a plan of care can be developed and before the decision can be made that it is safe to delegate a specialized health care activity to an unlicensed school employee. For example, unlicensed persons can usually assist special needs students with putting on or removing an article of clothing. However, in the rare instance that a student is at high risk for bone fracture with movement and handling, the school nurse would not delegate to an unlicensed person the task of assisting this student with clothing. The decision, however, cannot be made until the health assessment is completed.

When a student does not have an underlying medical condition that warrants specialized care, then the activity of "putting on or removing clothing," because it is otherwise an ordinary activity of daily living, may not require the act of delegation. While in this situation an unlicensed person might not need to be "delegated" the task, it may still be appropriate for the licensed health professional to provide direction and training

regarding techniques for assisting the student and promoting independence. Most of the specialized health care activities covered in these Guidelines, however, are not required/provided in school programs unless a student does have a health condition warranting specialized care.

It may be useful to review the section *Legal Issues: Clinical.* In particular, it is illegal for unlicensed school personnel to perform these specialized health care procedures without training, direction and supervision by an appropriately licensed health professional. It is also illegal for school administrators to delegate or assign these procedures to school personnel who are not licensed to perform them. Finally, it is illegal for school personnel to perform these procedures based strictly on training by a parent. In any of these situations, the school employee and/or school administrator may be liable for practicing nursing (or another health profession, as applicable) without a license. On the other hand, it is **essential** that parents share information about those aspects of specialized care that are unique to their child and that they participate in the assessment, planning and evaluation process.

In each individual situation, the decision to assign a specific procedure for a specific child must be made by the professional whose scope of practice includes the performance of that procedure. The delegating professional determines:

- **the level of care required;**
- **whether the procedure can be delegated; and**
- **the type of personnel to whom the care can be delegated (licensed, unlicensed, certified, noncertified).**

The building administrator determines which personnel in that category can be available to perform the procedure. This may require the administrator to review job descriptions (see *Personnel*), school policy and procedures, relevant bargaining agreements, personnel schedules and other responsibilities of the staff members in question. It will also require discussion of the plan with those employees who may be delegated the task. Utilization of the health professional to explain the nature of the care required by the student may be helpful. It is counterproductive and potentially unsafe to require an unwilling or reluctant staff member to provide the specialized care.

After providing sufficient training, the health professional determines whether to proceed with delegation of the task to the specific staff member(s) designated by the administrator.

The health professional remains responsible and legally accountable for any delegated task and must provide ongoing supervision to those carrying out the function.

The health professional may determine at any time that the procedure can no longer be delegated based on a change in the health status of the student or in the assigned staff member's performance of the care.

It is also essential to consider that these activity guidelines are written to address all potential settings, school environments and staffing patterns. While the "procedure box" indicates, for example, that the nurse can, depending on the student's health status, delegate taking vital signs to a teacher, it may be appropriate to do so in one situation, but not another. If an otherwise stable student needs his temperature, pulse and respirations checked each hour and the nurse has determined that it is reasonable for

this task to be performed by other school personnel, it might be feasible for the special education teacher of five student to do this; however, it might not be feasible for the regular education teacher of 25 students to take on this additional responsibility. In both cases, the administrator, teacher and nurse must collaborate with the family to find the best solution to meeting the health service needs of the student. In many situations, the required care may, indeed, be best provided by the school nurse or other member of the school health team (RN, LPN or trained nursing aide). However, when safe care does not require the immediate presence of the school nurse (or other health professional) and when sufficient nursing (or other health) services are not available, allowing other members of the school team to participate in the provision of care when they are willing and able to do so can:

- maximize efficient utilization of resources; and
- enhance opportunities for students with special health care needs to attend school in the least restrictive environment.

The information in each activity box is consistent with the rulings of the Connecticut State Board of Examiners for Nursing in matters relating to nursing delegation in effect at the time of publication. However, legal responsibility regarding delegation of licensed functions by physical therapists to unlicensed school personnel, with the exception of physical therapy assistants, as specified in C.G.S. Section 20-66, is currently unclear in Connecticut. As a result, while the health care activity may be within the scope of practice of the therapist, determination of whether the therapist can delegate to an unlicensed teacher aide, for example, should be made in keeping with current professional standards and guidelines for practice in this state. When delegation authority is unclear, or when a therapist is not available to provide ongoing supervision, the therapist can collaborate with the school nurse who may take on the delegation/supervision functions if the care is within the scope of nursing practice and is appropriate in the individual situation.

DEFINITIONS AND EXPLANATIONS FOR HEALTH CARE ACTIVITY BOXES

School Personnel who can appropriately provide care or assist the student:

means those personnel in schools who **may be competent** to provide the care in the **right circumstances**.

"May be competent" implies that:

- some persons in each category of personnel listed will be able to perform the procedure safely with the proper training and supervision, but not all will be able to do so.
- the person(s) is willing to take on the task.

The **"right circumstance"** means that:

- the health professional has determined that it is safe and appropriate to delegate the procedure for a specific student to a specific category or categories of unlicensed personnel included on the list;
- an employee in the category or categories specified is available, willing and able to take on the responsibility;
- provision of the care is within the scope of the employee's job description and not in conflict with other responsibilities;
- the administrator is in agreement that the employee may take on the responsibility; and
- the health care professional, after providing sufficient training, has determined that the specific individual is competent and the procedure can be safely delegated.

Consultation:

refers to the clinical consultation, assistance and/or in-service education that the health professional may need in order to be up-to-date in the specific knowledge and skills required to provide, and where applicable to teach others to provide, the required care.

Delegation Decision:

refers to the school health professional(s)

- whose license(s) to practice includes legal responsibility for clinical judgment regarding this specialized care;
- who must determine the level of care required by an individual student; and
- who must determine whether or not it is safe to assign the care to unlicensed personnel.

Training Needs and Supervision:

refers to the school health professional(s) who must

- determine what training is necessary before an individual is assigned a health care task;
- provide the necessary training to prepare the individual to perform the task in a safe and appropriate manner;
- determine, after training, that the individual has or has not sufficiently learned the necessary knowledge and skills to perform the task safely; and
- provide supervision to ensure quality of care for the student and ongoing competence of the individual performing the task.

Circumstances Which Require School Nurse or Therapist Action:

refers to those situations in which

- care should not be delegated to others; or
- immediate notification of and assessment by the school nurse, or therapist if appropriate, is required.

Remarks:

refers to additional requirements for, or information to be considered in, the provision of the specialized care in school.

SPECIALIZED HEALTH CARE ACTIVITIES

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HEALTH ASSESSMENT AND HEALTH CARE PLANS

SCHOOL PERSONNEL WHO CAN APPROPRIATELY PROVIDE CARE OR ASSIST THE STUDENT:
School nurse.

CONSULTATION:
Those responsible for providing care, training or supervision may need to obtain consultation from their clinical supervisor or from other health care providers in the community.

TRAINING NEEDS:
School nurses, by virtue of their educational preparation, licensure and previous experience should be competent in the health assessment of children, age 0 - 21 years.

SUPERVISION:
Supervision by a qualified nursing supervisor is desirable and recommended.

CIRCUMSTANCES WHICH REQUIRE SCHOOL NURSE ACTION:
For any student with actual or potential health care needs, the school nurse, in collaboration with the family, student, health care providers, and other school staff, as appropriate, should:

- complete the initial health assessment on school entry or re-entry;
- complete the health assessment component for special education eligibility evaluation;
- develop a health care plan to meet the student's special health needs in the school;
- collaborate with appropriate members of the school team;
- evaluate the health care services provided to the student; and
- revise the health care plan accordingly.

REMARKS:
Health assessment is the licensed function of physicians and registered nurses and can never be delegated to, or assumed by, other school personnel. The school nurse and/or school nurse supervisor will consult with the school medical advisor, as appropriate.

Definition:

Health assessment refers to the collection and analysis of information or data about a student's health situation to determine the student's state of health, patterns of functioning and need for health services, counseling and education. Health assessment by the school nurse includes data collection, data analysis and nursing diagnosis. It also includes identification of student health needs that require collaborative management with physicians, other health care providers and school team members. The assessment is systematic, goal oriented, directed by a body of knowledge and related to the needs of the student.

Individualized Health Care Plan is a detailed and orderly program of action designed to monitor, prevent, reduce, or eliminate identified health

problems in order to maintain or improve the student's health status and to promote the student's learning and positive coping. The process of planning care requires the establishment of care priorities, designation of student-specific goals, prescription of appropriate interventions and delineation of measurements for goal achievement.

Purpose:

Health assessment identifies student health needs by obtaining appropriate information about a student's health status, STRENGTHS, limitations and coping mechanisms in order to manage the student's health problems in the school setting.

Health care plan identifies solutions for diagnosed health problems (actual or potential); communicates the student's specific health needs, and the prescribed nursing and collaborative interventions for directing and evaluating the care given; and provides a mechanism for demonstrating accountability.

Equipment:

Student's cumulative health record; nursing record/progress notes; confidential storage of health assessment raw data and third-party health records; health history forms; health assessment summary form; Individualized Health Care Plan (IHCP) forms; release of information form(s).

Please note: Performance of a health assessment may require one or more visits to the student's and/or hospital where the child receives medical care.

VITAL SIGNS: TEMPERATURE, PULSE, RESPIRATION, BLOOD PRESSURE

SCHOOL PERSONNEL WHO CAN APPROPRIATELY PROVIDE CARE OR ASSIST THE STUDENT:
School nurse, RN, LPN, physical therapist, occupational therapist, teacher, teacher aide, school health aide, other certified personnel.

CONSULTATION:
Those responsible for providing care, training and supervision may need to obtain consultation from their clinical supervisor or from other health care providers in the community.

DELEGATION DECISION:
By the school nurse.

TRAINING AND SUPERVISION:
To be identified by the school nurse.

SUPERVISION:
To be determined/provided by the school nurse.

CIRCUMSTANCES WHICH REQUIRE SCHOOL NURSE ACTION:
Monitoring vital signs will not usually be delegated by the school nurse when there is evidence of fluctuating or abnormal temperature, pulse, respiration or blood pressure; or when blood pressure or pulse is to be taken before or after medication or treatment.
Rectal temperatures will not be delegated.

REMARKS:
Physical therapist may routinely take vital signs during physical therapy programs.
Route of temperature will be determined by the school nurse.

TEMPERATURE

Definition: Body **temperature** is a measurement of the amount of heat in the body. It is the difference between the heat produced and the heat lost.

Purpose: To determine if the student has a fever, and to what degree the temperature is elevated above his normal temperature.

Equipment: Glass thermometer (oral or rectal) or electronic thermometer, disposable thermometer sheath (optional), cotton ball, gauze or paper towel, soap and water, germicide solution and storage container, disposable gloves, plastic-lined waste container.

Precautions: The use of glass thermometers may be ill-advised with some special needs students; electronic thermometers with disposable protective sheaths are recommended. Rectal temperatures will frequently be contraindicated for students with certain cardiac and neurologic conditions and those with diarrhea. Follow student's health care plan; utilize infection control techniques and universal precautions, as appropriate.

Documentation: Vital signs can be documented on the flow sheet or treatment log. Any alteration in the student's status or health care plan should be documented by the school nurse on the student's health record.

PULSE

Definition: The **pulse** is the rhythmical expansion and contraction of the arteries resulting from the pumping action of the heart. **Apical pulse** is the heart beat heard through a stethoscope held to the chest at the apex of the heart.

Purpose: The pulse rate is an indirect measurement of heart action and the circulatory system.

Equipment: A watch or clock with second hand, or with a digital display of seconds. A stethoscope may be used to listen to an apical pulse or peripheral pulse.

Documentation: Vital signs can be documented on the flow sheet or treatment log. Any alteration in the student's status or health care plan should be documented by the school nurse on the student's health record.

RESPIRATION

Definition: **Respiration** is the process of inhaling and exhaling; breathing. **Respiratory rate** is the number of breaths taken per minute.

Purpose: To provide an indirect measure of lung functioning.

Equipment: A watch or clock with a second hand or with a digital display of seconds.

Documentation: Vital signs can be documented on the flow sheet or treatment log. Any alteration in the student's status or health care plan should be documented by the school nurse on the student's health record.

BLOOD PRESSURE

Definition: **Blood pressure** is the pressure of the blood against the walls of the arteries, primarily maintained by contraction of the left ventricle of the heart.

Purpose: To provide an index of circulatory system functioning (elasticity of the arterial walls, peripheral vascular resistance, efficiency of the heart as a pump, blood volume).

Equipment: Sphygmomanometer with correct size cuff, stethoscope.

Documentation: Vital signs can be documented on the flow sheet or treatment log.

Record the reading on the blood pressure flow chart and blood pressure graph; compare it with previous values. Record 1st phase/4th phase or 1st phase/4th phase/5th phase and indicate the student's position (lying [L], standing [St], sitting [Si]), which limb was used (right arm [RA], left arm [LA], right leg [RL], left leg [LL]) and the size of the blood pressure cuff. Any alteration in the student's status or health care plan should be documented by the school nurse on the student's health record.

HEIGHT AND WEIGHT

SCHOOL PERSONNEL WHO CAN APPROPRIATELY PROVIDE CARE OR ASSIST THE STUDENT:
School nurse, RN, LPN, occupational therapist, physical therapist, teacher, teacher aide, school health aide, nutritionist, other certified personnel.

CONSULTATION:
Those responsible for providing care, training and supervision may need to obtain consultation from their clinical supervisor or from other health care providers in the community.

DELEGATION DECISION:
By the school nurse.

TRAINING AND SUPERVISION:
To be determined/provided by the school nurse.

CIRCUMSTANCES WHICH REQUIRE SCHOOL NURSE ACTION:
Monitoring of **height** will not usually be delegated by the school nurse when there is evidence of arrested growth.
Monitoring of **weight** will not usually be delegated by the school nurse when there is evidence of frequent fluctuations or dramatic changes in weight.

REMARKS:
Calibrate scales annually and record date.

HEIGHT

Definition: **Height** is the distance from the base to the top of something. The measurement from the bottom of the heel to top of the head.

Purpose: To monitor growth and evaluate treatment.

Equipment: Appropriate equipment must be available and calibrated annually. Measuring scale marked in increments of one-eighth of an inch and mounted to a vertical, flat surface (wall), headboard about 6 inches wide that makes a right angle to the measuring scale; "infant-type" measuring board with a rigid headpiece and movable footpiece for horizontal measurements.

Precautions: Assure student safety.

Documentation: Document height on Growth Curve Chart. Any alteration in the student's status or health care plan should be documented by the school nurse on the student's health record.

WEIGHT

Definition: **Weight** is a measure of the heaviness or mass of an object.

Purpose: To monitor growth and evaluate treatment.

Equipment: A beam balance scale with a platform and nondetachable free-sliding weights. The scale should be marked in increments of one-quarter of a pound and must have a zeroing adjustment. Spring balance scales are not recommended because of progressive loss of accuracy and increments generally greater than one-quarter of a pound. For a nonambulatory student, it is recommended that a wheelchair platform scale be utilized when appropriate.

Precautions: Assure student safety. **Students should not be held by a staff member on a scale.**

Documentation: Record weight on Growth Curve Chart.

ORAL HYGIENE, FINGER NAIL CARE, HAIR CARE AND SKIN CARE

SCHOOL PERSONNEL WHO CAN APPROPRIATELY PROVIDE ROUTINE CARE OR ASSIST THE STUDENT:
School nurse, RN, LPN, physical therapist, occupational therapist, teacher, teacher aide, school health aide, other certified personnel.

CONSULTATION:
Those responsible for providing care, training and supervision may need to obtain consultation from their clinical supervisor or from other health care providers in the community.

DELEGATION DECISION:
By the school nurse/physical therapist/occupational therapist/speech language pathologist, as appropriate.

TRAINING AND SUPERVISION:
To be determined/provided by the school nurse, physical therapist, occupational therapist, and/or speech language pathologist, as appropriate.

CIRCUMSTANCES WHICH REQUIRE SCHOOL NURSE ACTION:
Evidence of rash, skin breakdown, infection and/or impaired circulation.

REMARKS:
May require physician's authorization and parent/guardian permission.
If specifically ordered for a student's care, supplies should be provided by parent/guardian.
If toe nail care is appropriate, it may **only** be done by a school nurse or physical therapist.

ORAL HYGIENE

Definition:	**Oral hygiene** means cleansing of the mouth, gums, teeth and tongue.
Purpose:	To maintain the teeth, mouth and gums in a healthy condition; to lessen offensive mouth odor by decreasing the bacterial count; to prevent inflammation and infection of the oral structures; to stimulate the appetite; to provide a sense of health and comfort; to promote independence in activities of daily living.
Equipment:	Student's own soft bristled toothbrush or tooth sponge and student's own towel, toothpaste, dental floss, glass of tepid water, padded tongue blade, empty basin, drinking straw, swabs, moisturizer for lips and mouth, mirror, plastic-lined waste container, disposable gloves.
Documentation:	Document oral hygiene on the student's health record or treatment log. Any alteration in the student's status or health care plan should be documented by the school nurse on the student's health record.

NAIL CARE

Definition: **Nail care** means cleaning the student's fingernails and nail beds, and training his/her fingernails.

Purpose: To minimize infection of mouth, nose and skin; to decrease injury from scratching; to improve the student's appearance; to promote independence in activities of daily living.

Equipment: Soap and water at the sink or in a basin, very soft nail brush, orangewood stick, towel, hand lotion or prescribed skin lubricant, manicure scissors, nail clippers, nail file, plastic-lined waste container.

Documentation: Document nail care on the student's health record or treatment log. Any alteration in the student's status or health care plan should be documented by the school nurse on the student's health record.

HAIR CARE

Definition: **Hair care** means brushing, combing and styling the student's hair.

Purpose: To stimulate the circulation to the scalp; to inspect the scalp for signs of irritation or infection; to inspect the hair for lice; to improve the student's appearance and self-esteem; to promote independence in activities in daily living.

Equipment: Student's own towel, brush, and comb; mirror, plastic-lined waste container.

Documentation: Document hair care on the student's health record or treatment log. Any alteration in the student's status or health care plan should be documented by the school nurse on the student's health record.

SKIN CARE

Definition: **Skin care** means cleaning and lubricating the student's skin.

Purpose: To maintain the integrity of the skin; to reduce the incidence of infection; to improve the student's appearance and comfort; to stimulate circulation.

Equipment: Soap and water, wash cloth, towel, skin lubricant.

Documentation: Document skin care on the student's health record or treatment log. Any alteration in the student's status or health care plan should be documented by the school nurse on the student's health record.

APPLY CLEAN DRESSING

SCHOOL PERSONNEL WHO CAN APPROPRIATELY PROVIDE CARE OR ASSIST THE STUDENT:
School nurse, RN, LPN, physical therapist, occupational therapist, teacher, teacher aide, school health aide, other certified personnel.

CONSULTATION:
Those responsible for providing care, training and supervision may need to obtain consultation from their clinical supervisor or from other health care providers in the community.

DELEGATION DECISION:
By the school nurse.

TRAINING AND SUPERVISION:
To be determined/provided by the school nurse.

CIRCUMSTANCES WHICH REQUIRE SCHOOL NURSE ACTION:
Evidence of infection, bleeding, drainage or decubitus ulcer; complaints of pain or discomfort.

REMARKS:
May require a physician's order and parent/guardian authorization.
If specifically ordered for a student's care, supplies should be provided by parent/guardian.

Definition:	**Dressing** is a therapeutic material applied to a wound; **clean** means not sterile, but with a minimum of pathogenic organisms.
Purpose:	To protect a wound from infection; to absorb fluids or discharge; to apply pressure; to prevent or reduce swelling; to immobilize or support an area of the body.
Equipment:	Disposable gloves, clean dressing, hypoallergenic tape, scissors, medication (if ordered), skin preparation (if ordered), antiseptic solution (if ordered), plastic-lined waste container and work surface.
Documentation:	Document clean dressing application on the student's health record or treatment log. Any alteration in the student's status or health care plan should be documented by the school nurse on the student's health record.

APPLY STERILE DRESSING

SCHOOL PERSONNEL WHO CAN APPROPRIATELY PROVIDE CARE OR ASSIST THE STUDENT:
School nurse, RN, LPN or physical therapist.

CONSULTATION:
Those responsible for providing care, training and supervision may need to obtain consultation from their clinical supervisor or from other health care providers in the community.

DELEGATION DECISION:
By the school nurse.

TRAINING AND SUPERVISION:
To be determined/provided by the school nurse.

CIRCUMSTANCES WHICH REQUIRE SCHOOL NURSE ACTION:
Evidence of increased drainage; the dressing requires reinforcement; deterioration of the wound; or the wound is not healing.

REMARKS:
Requires written order from the physician and parent/guardian authorization.
Parent/guardian to provide supplies.
In emergency situations, may be done without physician's order.

Definition:	**Dressing** is a therapeutic material applied to a wound; **sterile** means without pathogenic organisms; **sterile technique** is a means of carrying out the procedure without contamination by pathogenic organisms.
Purpose:	To protect the wound site from infection; to prevent further contamination of an already infected wound; to absorb fluids or discharge; to apply medication; to apply pressure; to prevent or reduce swelling; to immobilize or support an area of the body.
Equipment:	Sterile and unsterile gloves; dry sterile dressing as ordered, e.g., sterile 4x4s, sterile applicators, sterile cleansing solution (if ordered), e.g., sterile saline; sterile ointment/solution, if ordered; sterile scissors if appropriate; plastic apron if soiling is likely; hypoallergenic tape; plastic-lined waste container with closures, disposable protective padding if necessary to protect the student's clothing, cot and/or work surface.
Documentation:	Document sterile dressing change on the student's health record or treatment log. Any alteration in the student's status or health care plan should be documented by the school nurse on the student's health record.

CAST CARE

SCHOOL PERSONNEL WHO CAN APPROPRIATELY PROVIDE CARE OR ASSIST THE STUDENT:
School nurse, RN, LPN.

CONSULTATION:
Those responsible for providing care, training and supervision may need to obtain consultation from their clinical supervisor or from other health care providers in the community.

DELEGATION DECISION:
By the school nurse.

TRAINING AND SUPERVISION
To be determined/provided by the school nurse.

CIRCUMSTANCES WHICH REQUIRE SCHOOL NURSE ACTION:
Evidence of skin breakdown, impaired circulation, bleeding, pain, infection, fever, changes in cast integrity, or insertion of foreign body.

REMARKS:
May require a physician's order and parent authorization.

Definition: **A cast** is a solid mold of a part of the body usually applied to a student's extremity or trunk for treatment purposes.
Cast care is the ongoing assessment and protocol designed to promote optimum treatment outcome for the student and to protect the cast from damage.

Purpose: To immobilize the body part in the desired anatomical position.
To protect and keep the cast clean and intact.
To prevent or detect untoward effects from cast pressure and immobilization.

Equipment: Soap and water, rubbing alcohol, scouring powder, moleskin, flashlight, adhesive tape.

Documentation: Document the cast care on the student's health record or treatment log. Any alteration in the student's status or health care plan should be documented by the school nurse on the student's health record.

PREVENTION AND CARE OF DECUBITUS ULCERS

SCHOOL PERSONNEL WHO CAN APPROPRIATELY PROVIDE CARE OR ASSIST THE STUDENT:

a) **Prevention:** General management of decubitus ulcers to promote healing can be provided by everyone:
School nurse, RN, LPN, physical therapist, occupational therapist, teacher, teacher aide, school health aide, other certified personnel.

b) **Care:** The specific wound care of the decubitus ulcer is the responsibility of the school nurse, RN, or LPN.

CONSULTATION:

Those responsible for providing care, training and supervision may need to obtain consultation from their clinical supervisor or from other health care providers in the community.

DELEGATION DECISION:

By the school nurse.

TRAINING AND SUPERVISION:

a) To be determined/provided by the school nurse/physical therapist/occupational therapist.
b) To be determined/provided by the school nurse.

CIRCUMSTANCES WHICH REQUIRE SCHOOL NURSE ACTION:

Any change in skin integrity.
In situations in which students are at risk for skin breakdown due to incontinence, alteration in circulation or sensation, pressure from appliances or position, a nursing care plan for prevention and care must be developed and communicated.

REMARKS:

Physician's order and parent authorization is required for specific wound care.
Parent/guardian will provide specialized supplies for care.

Definition: **A decubitus ulcer** is a localized area of skin breakdown with gradual disintegration and necrosis of tissue. A decubitus ulcer may be caused by too much pressure on a body part leading to impaired circulation or may be started by an abrasion, excoriation, pustule or abscess. Multiple decubitus ulcers are referred to as "**decubiti**".

Purpose: **Prevention of decubitus ulcer:**
In students at risk for skin breakdown, efforts can be made to make the student comfortable and to promote skin integrity and circulation to the area.

Care of decubitus ulcer:
In students with skin breakdown, efforts should be made to (1) interrupt the destructive process by minimizing pressure over the affected area and (2) promote healing by restoration of circulation. Often physicians will prescribe a decubitus ulcer care regimen.

Equipment: As ordered; alternate positioning aids.

Documentation: Document prevention and care of decubitus ulcer on the student's health record or treatment log. Any alteration in the student's status or health care plan should be documented by the school nurse on the student's health record.

OSTOMY MANAGEMENT AND CARE

SCHOOL PERSONNEL WHO CAN APPROPRIATELY PROVIDE CARE OR ASSIST THE STUDENT:

a) Management: (emptying, and monitoring the integrity of the appliance/bag): School nurse, RN, LPN, physical therapist, occupational therapist, teacher, teacher aide, school health aide, other certified personnel.

b) Care (of stoma and changing of appliance): School nurse, RN, LPN.

CONSULTATION:

Those responsible for providing care, training and supervision may need to obtain consultation from their clinical supervisor or from other health care providers in the community. An enteral stoma therapist may be the best community resource and may be available through a major medical supply pharmacy or community nursing agency.

DELEGATION DECISION:

By the school nurse.

TRAINING AND SUPERVISION:

To be determined/provided by the school nurse.

CIRCUMSTANCES WHICH REQUIRE SCHOOL NURSE ACTION:

The school nurse must be notified when there is evidence of skin breakdown, bleeding, any alteration in the appearance of the stoma, or any change in the student's health status.

REMARKS:

May require physician's order and parent/guardian authorization.
Parent/guardian to provide specialized supplies for care.

Definition: An **ostomy** is a surgically created opening through the skin to the intestine or urinary tract to provide for elimination of bodily wastes. "Stoma care" and "ostomy care" are frequently used interchangeably. Urinary stomas and colostomies usually drain into a bag. Continent urinary reservoirs do not drain continuously and require intermittent catheterization. Usually no bag or appliance is needed. At times a small dressing can be used to cover the stoma. Most urinary stomas may be catheterized to obtain a specimen.

Purpose: To maintain continence; to keep the stoma and the surrounding skin in good condition; to encourage as much self-care as developmentally or physically possible; to facilitate acceptance of the student in school; to replace a bag that is leaking.

Equipment: Clean ostomy bag, skin protectors and adhesives (as provided), disposable wash cloth and towel, warm water and mild soap, stoma measuring guide, collection container, plastic-lined trash container, and disposable gloves. For catheterization, catheter (as ordered) or double lumen catheters for specimens.

Documentation: Document stoma care on the student's health record or treatment log. Any alteration in the student's status or health care plan should be documented by the school nurse on the student's health record. Many students with ostomies provide self-care and empty the bag without the need for documentation. If there is a need to document intake and output, record on a treatment log.

USE OF COOL AND WARM APPLICATIONS

SCHOOL PERSONNEL WHO CAN APPROPRIATELY PROVIDE CARE OR ASSIST THE STUDENT:

a) **For cool applications**: School nurse, RN, LPN, physical therapist, occupational therapist, teacher, teacher aide, school health aide, other certified personnel.
b) **For warm application**: School nurse, RN, LPN, physical therapist, occupational therapist.

CONSULTATION:

Those responsible for providing care, training and supervision may need to obtain consultation from their clinical supervisor or from other health care providers in the community.

DELEGATION DECISION:

By the school nurse.

TRAINING AND SUPERVISION:

a) To be determined/provided by the school nurse, physical therapist and/or occupational therapist.
b) To be determined/provided by the school nurse.

REMARKS:

Cool and warm applications may require a physician's order and parent/guardian authorization.
Cool applications are the appropriate treatment for the first 24 hours following an injury.
Caution should be used when applying warm applications, especially to the abdomen or calf or following trauma.
Special precautions should be taken for students who have diabetes, heart disease, cancer, unstable basal body temperature, impaired sensation or other medical conditions.
If specifically ordered for a student's care, supplies should be provided by the parent/guardian.

Definition: Therapeutic use of physical device applied to the student's body to bring about a change in temperature either locally or systemically. The outcome is modified by the method and interval of the application, the condition of the body part, general health, the amount of skin covered by the application or the extent of warmth or cold utilized.

Purpose: **Cool applications** are used to reduce swelling and inflammation, diminish pain by local anesthesia, stop bleeding through vasoconstriction, decrease metabolism, lower general body temperature and promote mobility or range of motion exercises. **Warm applications** are used to increase circulation through vasodilation, ease aching muscles, promote healing, promote comfort, provide general warmth, soften exudate, or increase metabolism.

Equipment: Will vary with the procedure ordered.

Documentation: Document application of heat or cold on the student's health record or treatment log. Any alteration in the student's status or health care plan should be documented by the school nurse on the student's health record.

PREPARE NOURISHMENT
Specified in Health Care Plan

SCHOOL PERSONNEL WHO CAN APPROPRIATELY PROVIDE CARE OR ASSIST THE STUDENT:
School nurse, RN, LPN, occupational therapist, physical therapist, teacher, food service personnel, teacher aide, school health aide and other certified personnel.

CONSULTATION:
Those responsible for providing care, training and supervision may need to obtain consultation from their clinical supervisor or from other health care providers in the community.

DELEGATION DECISION:
By the school nurse.

TRAINING AND SUPERVISION:
To be determined/provided by school nurse and/or occupational therapist.

REMARKS:
Student and parent may inform school personnel of procedure used at home.
Parent shall provide specialized nourishment and/or equipment needed.
Specialized nourishment may require physician's order and parent/guardian authorization.

Definition: **Nourishment** means solid and liquid nutrients.
Specialized nourishment means solid and/or liquid nutrients prepared to meet the special nutritional needs of a student.
Prepare nourishment means to make the nutrients ready to serve or administer to the student in a manner that will enhance the student's nutritional status, learning, enjoyment and participation in eating or receiving special nourishment.

Purpose:
a) To provide a nutritional supplement and/or a specialized diet.
b) To prepare nutrients and fluids in a form or consistency that the student can safely tolerate.

Equipment: As specified in each student's health care plan; may require equipment such as a blender.

Documentation: Document preparation of nourishment, as specified in the health care plan, on the student's health record or treatment log. Any alteration in the student's status or health care plan should be documented by the school nurse on the student's health record.

FEED STUDENT (orally)

SCHOOL PERSONNEL WHO CAN APPROPRIATELY PROVIDE CARE OR ASSIST THE STUDENT:
School nurse, RN, LPN, occupational therapist, physical therapist, teacher, speech/language pathologist, teacher aide, school health aide, and other certified personnel.

CONSULTATION:
Those responsible for providing care, training and supervision may need to obtain consultation from their clinical supervisor or from other health care providers in the community.

DELEGATION DECISION:
By the school nurse and/or occupational therapist/speech language pathologist.

TRAINING AND SUPERVISION:
To be determined/provided by the school nurse, speech and language pathologist and/or occupational therapist.

CIRCUMSTANCES WHICH REQUIRE SCHOOL NURSE ACTION:
A change in the student's status requires school nurse evaluation to determine if alteration in the health care plan is indicated.

REMARKS:
Student and/or parent/guardian may inform school personnel of procedure used at home.

Definition:	**Feed student** (orally) means to provide nutrients and fluids to a student who is unable to eat without assistance.
Purpose:	To prevent dehydration and fluid retention; to provide practice in age-appropriate eating skills; to enhance the student's nutritional status.
Equipment:	Adaptive eating and drinking devices; adaptive seating or positioning equipment; measuring containers; towel to protect student clothing; warm, wet wash cloth; suction equipment (as indicated). Disposable gloves may be indicated if intraoral handling is anticipated.
Documentation:	Document oral feeding of student on the health record or treatment log. Any alteration in the student's status or health care plan should be documented by the school nurse on the student's health record.

TOTAL PARENTERAL NUTRITION
high-calorie intravenous (IV) feeding

SCHOOL PERSONNEL WHO CAN APPROPRIATELY PROVIDE CARE OR ASSIST THE STUDENT:
School nurse, RN.

CONSULTATION:
Those responsible for providing care, training and supervision may need to obtain consultation from their clinical supervisor or from other health care specialists in the community, prior to giving care or training/supervising other nurses.

SUPERVISION:
To be determined/provided by the school nurse.

CIRCUMSTANCES WHICH REQUIRE SCHOOL NURSE ACTION:
This procedure is never delegated.

REMARKS:
Requires specific prescription from physician and parent/guardian permission.
Parent/guardian will provide nourishment and equipment.
IV fluids must be infused by a pump in school.
TPN should be hung and completed at home (such as overnight), whenever possible.

Definitions:

Total parenteral nutrition (TPN) refers to the administration of either of the following or a combination of:
Hyperalimentation — any solution with a glucose concentration of 20 percent or above for adults, 12.5 percent or above for children, which is administered through a catheter into a central vein; and
Lipids (fat emulsion) — any solution containing essential fatty acids which is administered through a catheter into a central vein.

A **central intravenous (IV) line** refers to those catheters whose tips lie in the large central blood vessels.

To administer IV fluids or TPN by central venous route shall mean any or all of the following: adding containers of IV fluids/hyperalimentation/fat emulsion; and monitoring the flow rate to comply with the physician's order.

Purpose:

To provide nutrients by way of the intravenous route as a substitute for oral, nasogastric or gastrostomy feeding when these are ineffective, undesirable or hazardous; to supplement feedings for those individuals

demonstrating large nutritional deficiencies or increased caloric requirements; or to put the gastrointestinal tract at rest.

Equipment: IV pole, solutions, IV tubing, cannula clamp, injection caps (i.e., buffalo caps), alcohol swabs, disposable gloves, tape, 3 cc syringes with 20-gauge, 1-inch needles, heparinized saline or saline (as ordered), filters, infusion pumps, plastic-lined waste container, mask and padded kelly clamp.

Documentation: Document high calorie intravenous feeding on the student's health record or treatment log. Any alteration in the student's status or health care plan should be documented by the school nurse on the student's health record.

GASTROSTOMY FEEDING
(tube already in place)

SCHOOL PERSONNEL WHO CAN APPROPRIATELY PROVIDE CARE OR ASSIST THE STUDENT:

DRIP (HUNGBAG) METHOD:

a) Initiation of drip feed: School nurse, RN, LPN,
b) Monitoring drip feed: School nurse, RN, LPN, physical therapist, occupational therapist, teacher, school health aide, other certified personnel.*

BOLUS METHOD:

School nurse, RN, LPN

CONSULTATION:

Those responsible for providing care, training and supervision may need to obtain consultation from their clinical supervisor or from other health care providers in the community.

DELEGATION DECISION:

By the school nurse.

TRAINING AND SUPERVISION:

Must be determined/provided by the school nurse.

CIRCUMSTANCES WHICH REQUIRE SCHOOL NURSE ACTION:

Any change in the student's status or evidence of obstruction or malabsorption, infection at insertion site, or displacement of the tube.

*** If the student with a drip (hungbag) gastrostomy feeding is monitored by unlicensed personnel, a nurse must be in the building.**

REMARKS:

Requires prescription from physician and parental permission.
Parent will provide specialized nourishment and equipment for changing or replacing a gastrostomy tube.

Definition: A **gastrostomy** is the surgical construction of a permanent opening from the external surface of the abdomen into the stomach, usually for inserting a feeding tube. The **tube** is a flexible rubber catheter or button held in place by a balloon or flattened area at lip inside stoma.

Purpose: To provide a safe method of feeding a student who cannot tolerate oral feeding or receive adequate nourishment by other means.

Equipment: Prescribed amount of formula/nourishment at room temperature, 50 or 60 cc syringe with catheter tip or feeding bag and infusion pump, clamp, prescribed amount of water, paper or hypoallergenic tape, 2x2 gauze squares, small rubber bands, disposable gloves (if indicated) and plastic-lined waste container.

Precautions: If the gastrostomy tube comes out of the stoma, tape several pieces of gauze over the stoma and follow the student's health care plan for whom to notify and whether to reinsert the tube. Excessive pulling on the tape around the gastrostomy tube may cause widening of the stoma with leakage of irritating gastric juices.

Documentations: Document gastrostomy feedings on the student's health record or treatment log. Any alteration in the student's status or health care plan should be documented by the school nurse on the student's health record.

NASOGASTRIC TUBE FEEDING
(tube already in place)

SCHOOL PERSONNEL WHO CAN APPROPRIATELY PROVIDE CARE OR ASSIST THE STUDENT:
School nurse, RN, LPN.

CONSULTATION:
Those responsible for providing care, training and supervision may need to obtain consultation from their clinical supervisor or from other health care providers in the community.

DELEGATION DECISION:
By the school nurse.

SUPERVISION:
To be determined/provided by the school nurse.

CIRCUMSTANCES WHICH REQUIRE SCHOOL NURSE ACTION:
Gagging, coughing, nausea, vomiting, respiratory difficulty, problem with tube patency or placement, blood in the stool or other change in student's baseline health status.

REMARKS:
Requires prescription from physician and written parent/guardian authorization.
Parent will provide nourishment and equipment.
Reinsertion of the nasogastric tube should never be attempted in the school setting.

Definition: A **nasogastric tube** is a plastic or rubber tube inserted through the student's nostril, down his/her esophagus and into his/her stomach.

Purpose: To administer nutrients, medications and liquids directly into the gastrointestinal tract when the student is unable to obtain adequate nourishment by mouth.

Equipment: Measured amount of formula or liquid nourishment, measured amount of water, 50 cc syringe with catheter tip, hypoallergenic tape, clamp, stethoscope, glass of water.

Documentation: Document nasogastric tube feeding on the student's health record or treatment log. Any alteration in the student's status or health care plan should be documented by the school nurse on the student's health record.

TEMPORARY INSERTION OF A FOLEY CATHETER GASTROSTOMY TUBE

SCHOOL PERSONNEL WHO CAN APPROPRIATELY PROVIDE CARE OR ASSIST THE STUDENT:
School nurse, RN and LPN.

CONSULTATION:
Those responsible for providing care, training and supervision may need to obtain consultation from their clinical supervisor or from other health care providers in the community. The school nurse must consult with the student's physician to determine whether a displaced gastrostomy tube (G-tube) should be replaced in school. If needed, the school nurse will obtain consultation from the school nurse supervisor/director or from appropriate nursing personnel in a local or community agency.

DELEGATION DECISION:
By the school nurse.

SUPERVISION:
To be determined/provided by the school nurse.

CIRCUMSTANCES WHICH REQUIRE SCHOOL NURSE ACTION:
In a particular circumstance, nursing assessment may determine that replacement of the catheter requires physician evaluation, such as when displacement is traumatic (i.e., frank bleeding or swelling is present) and when reinsertion is difficult. A foley catheter may be temporarily used to hold the stoma patent regardless of the type of gastrostomy. In some children whose stoma may close quickly, the G-tube may need to be replaced within 1 to 2 hours. It is recommended that the same size foley be used, or as close to the size as possible. If insertion of the tube is difficult, cover the site with a dry dressing or Band-Aid and notify the parent(s) and physician.

REMARKS:
Physician's order and parent/guardian permission required.

Definition: A **gastrostomy** is a surgical opening into the stomach through the surface of the abdomen. The **gastrostomy tube (G-tube)** is a rubber catheter or plastic device held in place by a balloon or a widened flat mushroom-shaped dome at the tip of the tube inside the stomach. The purpose of a G-tube is for feeding or providing liquids to the student. **If the G-tube falls out, or is accidentally pulled out, a new tube needs to be inserted.**

Purpose: To maintain the patency of the stoma. To provide the student with food, fluids and/or medications.

Equipment: Sterile foley catheter (G-tube) size as ordered by the physician, 10 cc syringe, water soluble jelly (e.g., Lubrifax, Lacrilube, Surgilube), sterile normal saline, 2x2 gauze, 1" wide tape, disposable gloves, clamp or plug, feeding syringe with catheter tip, soapy water, and half-strength H_2O_2.

Documentation: Document reinsertion of foley catheter gastrostomy tube on the student's health record or treatment log. Any alteration in the student's status or health care plan should be documented by the school nurse on the student's health record.

INTRAVENOUS FLUIDS
(monitor)

SCHOOL PERSONNEL WHO CAN APPROPRIATELY CARE OR ASSIST THE STUDENT:
School nurse, RN, LPN.

CONSULTATION:
Those responsible for providing care, training and supervision may need to obtain consultation from their clinical supervisor or from other health care providers in the community.

DELEGATION DECISION:
By the school nurse. This procedure is never delegated to unlicensed personnel. Monitoring of the IV can be delegated to a LPN; admixture of IV fluids or medication and termination cannot be delegated to a LPN.

SUPERVISION:
To be determined/provided by the school nurse.

CIRCUMSTANCES WHICH REQUIRE SCHOOL NURSE ACTION:
Regulation of the drip (if manually regulating rate with a flow dial); swelling, redness or leakage at the insertion site; other complications; a change in the student's status; or termination of the IV line. If monitoring of the IV therapy is delegated to a LPN, the school nurse must be in the building.

REMARKS:
Requires physician's order and parent/guardian permission.
The parent/guardian will provide equipment and prescribed IV solutions.
IV fluids must be infused by a pump.
A child on peripheral IV fluids for severe dehydration should not be in school.
It is recommended that admixture of fluids be done by the pharmacy.

Definition:	Administration of prescribed fluids via an intravenous route using a pump infusion method.
Purpose:	To provide or supplement hydration and nutrition by intravenous route, when other feeding routes are ineffective (oral, G-tube).
Equipment:	IV pole, prescribed solutions, clamp, alcohol wipes, tape, IV tubing (disposable set-up), 2 cc syringe, infusion pump.
Documentation:	Document intravenous fluids on the student's health record or treatment log. Any alteration in the student's status or health care plan should be documented by the school nurse on the student's health record.

INTAKE/OUTPUT

SCHOOL PERSONNEL WHO CAN APPROPRIATELY PROVIDE CARE OR ASSIST THE STUDENT:
School nurse, RN, LPN, physical therapist, occupational therapist, teacher, teacher aide, school health aide, other certified personnel.

CONSULTATION:
Those responsible for providing care, training and supervision may need to obtain consultation from their clinical supervisor or from other health care providers in the community.

DELEGATION DECISION:
By the school nurse. The measurement and recording of gastric and parenteral fluids cannot be delegated to anyone other than a licensed nurse.

TRAINING AND SUPERVISION:
To be determined/provided by the school nurse.

CIRCUMSTANCES WHICH REQUIRE SCHOOL NURSE ACTION:
Alteration in student's usual pattern of nutrition and elimination.

REMARKS:
May be initiated by the school nurse or ordered by physician.
Parent/guardian will supply special equipment, if needed.

Definition:	**Intake/output** means the accurate measurement and recording of the fluids taken into the body and the fluids released from the body, excluding gastric and parenteral fluids for the purposes of this document.
Purpose:	To calculate the need to increase or decrease fluid intake to help determine a diagnosis, to assess treatment effectiveness, or to determine if the body is retaining fluids.
Equipment:	Measuring containers.
Documentation:	Document intake/output procedure on the student's health record or treatment log. Any alteration in the student's status or health care plan should be documented by the school nurse on the student's health record.

ASSIST STUDENT TO TAKE OWN MEDICATION

(including meter-dose inhalers)

SCHOOL PERSONNEL WHO CAN APPROPRIATELY PROVIDE CARE OR ASSIST THE STUDENT:

A school nurse or, in the absence of such nurse, any other nurse licensed pursuant to the provisions of Chapter 378, the principal of or any teacher in a school, according to Connecticut General Statutes, Section 10-212a.

CONSULTATION:

Those responsible for providing care, training and supervision may need to obtain consultation from their clinical supervisor or from other health care providers in the community.

DELEGATION DECISION:

By the school nurse.

TRAINING AND SUPERVISION:

To be determined/provided by the school nurse.

CIRCUMSTANCES WHICH REQUIRE SCHOOL NURSE ACTION:

Assisting the student to take his/her own medication will not usually be delegated by the school nurse if: the student's health status requires professional nursing judgment related to medication administration; the medication requires taking blood pressure or radial/apical pulse before or after self-administration; the medication requires nursing judgment to determine dose; or the medication is experimental.

REMARKS:

Requires prescription from physician and parental permission.
Administration of medications in school should follow the requirements of: C.G.S. Section 10-212a and State Regulations Sec. 10-212a-1 to 10-212a-7; the Nurse Practice Act, C.G.S. Sections 20-87a through 20-102; the Medical Practice Act, C.G.S. Sections 20-8a through 20-14j; and the Pharmacy Practice Act, C.G.S. Sections 20-163 through 20-185f. Policies and procedures of individual school districts must be observed. Parents supply medication.

Definition:	**Assist student to take own medication** means to help (if necessary) and supervise the student to self-administer his/her own medication.
Purpose:	To develop habits of safe self-care on the part of the student.
Equipment:	Will depend on kind of medication to be administered.
Documentation:	Document medication on the student's medication record. Any alteration in the student's status or health care plan should be documented by the school nurse on the student's health record.

GIVE ORAL MEDICATION

SCHOOL PERSONNEL WHO CAN APPROPRIATELY PROVIDE CARE OR ASSIST THE STUDENT:

A school nurse or, in the absence of such nurse, any other nurse licensed pursuant to the provisions of Chapter 378, the principal of or any teacher in a school, according to Connecticut General Statutes, Section 10-212a.

CONSULTATION:

Those responsible for providing care, training and supervision may need to obtain consultation from their clinical supervisor or from other health care providers in the community.

DELEGATION DECISION:

By the school nurse.

SUPERVISION:

To be determined/provided by the school nurse.

CIRCUMSTANCES WHICH REQUIRE SCHOOL NURSE ACTION:

Administration of medication will not usually be delegated by the school nurse if: the student's health status requires professional nursing judgment related to medication administration; the medication requires taking blood pressure, or radial/apical pulse before or after administration; the medication requires nursing judgment to determine dose; or the medication is experimental.

REMARKS:

Requires prescription from physician and parental permission.
Administration of medications in school should follow the requirements of: C.G.S. Section 10-212a and State Regulations Sec. 10-212a-1 to 10-212a-7; the Nurse Practice Act, C.G.S. Sections 20-87a through 20-102; the Medical Practice Act, C.G.S. Sections 20-8a through 20-14j; and the Pharmacy Practice Act, C.G.S. Sections 20-163 through 20-185f. Policies and procedures of individual school districts must be observed. Parents supply medication.

Definition:	**Giving oral medication** means placing of medication in the mouth of a student with the expectation that it will be swallowed into the esophagus and stomach.
Purpose:	To administer oral medication by eating, drinking or swallowing.
Equipment:	The correct amount of medication and glass of water.
Documentation:	Document medication on the student's medication record. Any alteration in the student's status or health care plan should be documented by the school nurse on the student's health record.

NONEMERGENCY INTRAMUSCULAR (IM) MEDICATIONS

SCHOOL PERSONNEL WHO CAN APPROPRIATELY PROVIDE CARE OR ASSIST THE STUDENT:
School nurse, RN, qualified LPN.

CONSULTATION:
Those responsible for providing care, training and supervision may need to obtain consultation from their clinical supervisor or from other health care providers in the community.

DELEGATION DECISION:
By the school nurse.

TRAINING AND SUPERVISION:
To be determined/provided by the school nurse.

CIRCUMSTANCES WHICH REQUIRE SCHOOL NURSE ACTION:
The school nurse should be consulted when clinically appropriate.

REMARKS:
Requires prescription from physician and parental permission.
Administration of medications in school should follow the requirements of: C.G.S. Section 10-212a and State Regulations Sec. 10-212a-1 to 10-212a-7; the Nurse Practice Act, C.G.S. Sections 20-87a through 20-102; the Medical Practice Act, C.G.S. Sections 20-8a through 20-14j; and the Pharmacy Practice Act, C.G.S. Sections 20-163 through 20-185f. Policies and procedures of individual school districts must be observed. Parents supply medication.

Definition: **Intramuscular (IM) Medication** refers to the administration of a medication by injection into a student's muscle.

Purpose: IM injections are preferable to subcutaneous injections for irritating drugs, for doses greater then 1.5 cc (but less than 5 cc), and for a more rapid onset or greater pharmacological effect. IM injections are preferable to IV injections for potent and toxic drugs and are used instead of IV injections for aqueous suspensions and for solutions in oil.

Equipment: Medication; appropriate sized syringes and needles; alcohol swabs; closeable puncture-resistant sharps container; and plastic-lined waste container.

Documentation: Document medication on the student's medication record. Any alteration in the student's status or health care plan should be documented by the school nurse on the student's health record.

GIVE MEDICATIONS VIA GASTROSTOMY/NASOGASTRIC TUBE

SCHOOL PERSONNEL WHO CAN APPROPRIATELY PROVIDE CARE OR ASSIST THE STUDENT:
School nurse, RN or LPN.

CONSULTATION:
Those responsible for providing care, training and supervision may need to obtain consultation from their clinical supervisor or from other health care providers in the community.

TRAINING NEEDS:
To be identified by the school nurse.

SUPERVISION:
To be determined/provided by the school nurse.

REMARKS:
Requires prescription from physician and parental permission. Administration of medications in school should follow the requirements of: C.G.S. Section 10-212a and State Regulations Sec. 10-212a-1 to 10-212a-7; the Nurse Practice Act, C.G.S. Sections 20-87a through 20-102; the Medical Practice Act, C.G.S. Sections 20-8a through 20-14j; and the Pharmacy Practice Act, C.G.S. Sections 20-163 through 20-185f. Policies and procedures of individual school districts must be observed. Parents supply medication.

Definition: A **nasogastric tube** is a plastic or rubber tube inserted through the student's nostril, down his/her esophagus and into his/her stomach. A **gastrostomy** is the surgical construction of a permanent opening from the external surface of the abdomen into the stomach, usually for inserting a feeding tube. The **gastrosotomy tube** is a flexible rubber catheter (or button) held in place by a balloon or a flattened area at lip inside stoma.

Purpose: To administer oral medication directly into the gastrointestinal tract when the student is unable to ingest it by eating, drinking or swallowing.

Equipment: Measured amount of medication, measured amount of water, 50 cc syringe with catheter tip, hypoallergenic tape, clamp, glass of water, stethoscope, plastic-lined waste container and disposable gloves.

Documentation: Document medications via gastrostomy/nasogastric tube on the student's medication record. Any alteration in the student's status or health care plan should be documented by the school nurse on the student's health record.

GIVE INTRAVENOUS (IV) MEDICATION
(with IV tube already in place)

SCHOOL PERSONNEL WHO CAN APPROPRIATELY PROVIDE CARE OR ASSIST THE STUDENT:
School nurse, RN.

CONSULTATION:
Those responsible for providing care, training and supervision may need to obtain consultation from their clinical supervisor or from other health care providers in the community.

SUPERVISION:
To be determined by the school nurse.

CIRCUMSTANCES WHICH REQUIRE SCHOOL NURSE ACTION:
Administering medication by IV is not to be delegated.
If the student has a private duty RN, the school nurse should confer daily and PRN with the RN to remain current with the student's health care needs.

REMARKS:
IV medications in schools should be limited to antibiotics and heparin lock care.
Requires prescription from physician and parental permission.
If tube is obstructed, the school nurse or RN will follow the individualized health care plan.
Administration of medications in school should follow the requirements of: C.G.S. Section 10-212a and State Regulations Section 10-212a-1 to 10-212a-7; the Nurse Practice Act, C.G.S. Sections 20-87a through 20-102; the Medical Practice Act, C.G.S. Sections 20-8a through 20-14j; and the Pharmacy Practice Act, C.G.S. Sections 20-163 through 20-185f.
Parent provides medication and special equipment or supplies. It is recommended that admixture of fluids be done by the pharmacy.

Definition: **Give IV medication** means to administer prescribed medications directly into the student's vein using an established intravenous line and method of administration.

Purpose: To provide a means for the administration of antibiotics.

Equipment: May include some or all of the following: IV solution and/or medication, IV tubing with drip chamber and clamp, infusion pump, alcohol wipes or other appropriate disinfectant, syringes with appropriate gauge needle, filter, extension tubing, intravenous standard Luer Lok injection cap, sterile gauze dressing, tape, heparinized saline, normal saline, disposable gloves, closeable puncture-resistant sharps container and plastic-lined waste container.

Documentation: Document intravenous medication on the student's medication record. Any alteration in the student's baseline status or health care plan should be documented by the school nurse on the student's health record.

CENTRAL LINE CARE

SCHOOL PERSONNEL WHO CAN APPROPRIATELY PROVIDE CARE OR ASSIST THE STUDENT:
School nurse and RN only.

CONSULTATION:
Those responsible for providing care, training and supervision may need to obtain consultation from their clinical supervisor or from other health care providers in the community. School nurses and RNs not currently certified in IV therapy must obtain training before providing central line care.

SUPERVISION:
To be determined/provided by the school nurse.

CIRCUMSTANCES WHICH REQUIRE SCHOOL NURSE ACTION:
Any change in student's baseline health status; swelling or redness in surrounding tissues; leakage; blood in line; elevated temperature/chills; change in respiratory status; or as specified in the student's health care plan.

REMARKS:
Requires physician's order and parent/guardian permission.
Parent/guardian provides supplies/equipment.

Definition: **Central line** is a catheter most frequently placed through the chest wall into the right atrial chamber of the heart or large central blood vessel; also referred to as a venous access device (VAD). Some central lines may be placed internally (implantable), such as portacaths, or externally, such as a Brovial or Hickman. In school, **central line care** should be limited to: ensuring that the dressing is occlusive and intact (when applicable); intervening in an emergency; or care required to access the line for IV medication. This procedure may include dressing reinforcement and/or heparin or saline flush.

Purpose: Long-term IV access to circulatory system for medications, fluids, and nutrients. Blood specimens may also be obtained through this catheter.

Equipment: Gloves, unsterile and sterile; antiseptic wipes/swabs, including alcohol and provodine-iodine; heparin, saline, and appropriate size syringe and needle as ordered; clamp, if necessary; 4x4 sterile gauze tape; antiseptic ointment; disposable plastic-lined waste bag; appropriate cap, if necessary; and a recloseable puncture-resistant sharps container.

Documentation: Document central line care on the student's health record or treatment log. Any alteration in the student's status or health care plan should be documented by the school nurse on the student's health record.

HEPARIN IV LOCK CARE

SCHOOL PERSONNEL WHO CAN APPROPRIATELY CARE OR ASSIST THE STUDENT:
School nurse and RN.

CONSULTATION:
Those responsible for providing care, training and supervision may need to obtain consultation from their clinical supervisor or from other health care providers in the community.

SUPERVISION:
To be determined/provided by the school nurse.

CIRCUMSTANCES WHICH REQUIRE SCHOOL NURSE ACTION:
Swelling or redness in surrounding tissue, leakage, blood in line, any change in the student's baseline health status; or as specified in student's health care plan.

REMARKS:
Requires prescription from the physician and parent/guardian permission.
Equipment is supplied by the family.

Definition:	**A heparin lock** is an intravenous (IV) device to maintain an access to a vein to intermittently administer medication or fluids. The special plug requires prescribed periodic injections of saline or heparinized saline. This procedure may include dressing reinforcement and/or heparin or saline flush.
Purpose:	To allow the student to maintain peripheral IV access in order to receive medically necessary IV medication and/or fluids; to promote maximum mobility with minimal limitations; to prevent dislodging of the IV.
Equipment:	3 mm syringe, alcohol swabs, saline or heparinized saline, disposable gloves and a recloseable puncture-resistant sharps container. (Heparinized saline is available in 2 cc single-dose vials with one unit of heparin per cc of saline.)
Documentation:	Document heparin lock care on the student's health record or treatment log. Any alteration in the student's baseline status or health care plan should be documented by the school nurse on the student's health record.

INSULIN PUMP

SCHOOL PERSONNEL WHO CAN APPROPRIATELY CARE OR ASSIST THE STUDENT:
School nurse and RN.

CONSULTATION:
Those responsible for providing care, training and supervision may need to obtain consultation from their clinical supervisor or from other health care providers in the community.

TRAINING AND SUPERVISION:
To be determined/provided by the school nurse.

CIRCUMSTANCES WHICH REQUIRE SCHOOL NURSE ACTION:
If the needle is potentially or actually dislodged; if there is any evidence of infection at the site; if the student has symptoms of hyperglycemia or hypoglycemia; if the pump's alarm system is activated; or if there is any other change in the student's health status.

REMARKS:
Requires prescription from the physician and parent/guardian permission.
Equipment is supplied by the family.

Definition: The **insulin pump** is a small, battery operated device, worn on a belt or in a pocket, which delivers a constant infusion of regular (fast acting) insulin. It is infused subcutaneously via a catheter or needle placed in the abdomen, hip or thigh.

Purpose: The purpose of insulin pump treatment is to provide the student with an alternative method of insulin delivery that more closely resembles the physiologic doses provided by the normal pancreas. In adults and older adolescents, the insulin pump is used to attain "tight" blood glucose control. Insulin pumps are seldom used by children and young adolescents except when their diabetes is medically difficult to manage.

Equipment:

A. The **insulin pump** will be worn by the student continuously day and night.

B. The **insulin reservoir** inside the pump holds between 100 and 300 units of U-100 regular insulin. An extra reservoir should be available for the student in the event that he/she happens to empty the reservoir or if the site needs to be changed.

C. The **infusion set**, a thin catheter which attaches to the reservoir, is either 24 or 42 inches in length. It ends in a 27-gauge subcutaneous

needle or a 24-gauge subcutaneous catheter, which is taped in place in the abdomen, hip or thigh. The insertion site must be changed and rotated to a new site every 2-3 days. There should be one or two infusion sets available in the event that a site change is needed by the student.

D. Pump **batteries** vary according to the type of pump being used. Some are rechargeable and must be changed each day, while others will run on hearing aid batteries which can last for a few weeks. If possible, an extra battery and a charger should be plugged in at school. If the pump uses hearing aid batteries, an extra set of these should be available.

E. **U-100 regular insulin** — an extra vial should be kept at school in case of depletion of the supply contained in the reservoir.

F. Tape or a tegaderm dressing is used to secure the needle or catheter in place. This should also be available in the event that a site change is needed.

Documentation: Document care on student's health record or treatment log. Any alteration in the student's status or health care plan should be documented by the school nurse on the student's record.

MONITORING SHUNT FUNCTIONING
(hydrocephalus)

SCHOOL PERSONNEL WHO CAN APPROPRIATELY PROVIDE CARE OR ASSIST THE STUDENT:
School nurse, RN, LPN, physical therapist, occupational therapist, teacher, teacher aide, school health aide, other certified personnel.

CONSULTATION:
Those responsible for providing care, training and supervision may need to obtain consultation from their clinical supervisor or from other health care providers in the community.

DELEGATION DECISION:
By the school nurse.

TRAINING AND SUPERVISION:
To be determined/provided by the school nurse.

CIRCUMSTANCES WHICH REQUIRE SCHOOL NURSE ACTION:
The school nurse needs to be notified when the student is showing signs or symptoms of shunt malfunction. These signs and symptoms include lethargy, irritability, headache, nausea and/or vomiting, stiff neck pain, visual disturbances, inability to move eyes in all directions, deterioration in writing or academic skills over a few days or weeks and increase in seizure activity or changes in levels of consciousness. Fever may be an indication of a shunt infection.

REMARKS:
Note any falls or blows to the head from balls or impacts with other objects. Often signs or symptoms of a shunt malfunction will show up hours or days after an injury.

Definition:

Shunt — a tube which drains cerebrospinal fluid from the ventricles in the brain so that it can be reabsorbed by the blood stream to help lessen the internal pressure on the brain.

Ventriculo-peritoneal (V.P.) shunt — the most common type of shunt that drains the cerebrospinal fluid from the ventricles to the peritoneal cavity (abdominal space) where it is reabsorbed by the blood vessels in the abdomen.

Ventriculo-atrial (V.A.) shunt — a rare type of shunt that drains the cerebrospinal fluid from the ventricles to the right atrium of the heart so that it is absorbed in the bloodstream.

Ventriculo-pulmonary shunt — a rare type of shunt that drains the cerebrospinal fluid from the ventricles into the pleural cavity (the space surrounding the lungs) where it is absorbed by the bloodstream.

Hydrocephalus — also called "water on the brain" is a condition where the cerebrospinal fluid of the brain builds up causing pressure on the brain. In a person **without hydrocephalus**, cerebrospinal fluid is made daily; circulates in and around the brain and spinal canal to cushion and protect the central nervous system; and is then reabsorbed by the bloodstream. In the student **with shunted hydrocephalus**, the cerebrospinal fluid cannot circulate normally due to a blockage which prevents the reabsorbtion. There is a slow increase in fluid on the brain and the student will show signs and symptoms of this pressure. If untreated, the pressure can cause damage to the nervous system and/or death.
Monitoring — observing for early signs of shunt malformation and preventing complications.

Purpose: To observe the student for signs and symptoms of a malfunctioning ventricular shunt; to record changes in the student and to notify the school nurse, family and physician.

Equipment: No equipment needed for observation by staff. School nurse will monitor the student's vital signs and check the student's vision.

Documentation: Document changes in the student with specific descriptions of the signs and symptoms of a shunt malfunction on the student's health record or treatment log. In students with shunted hydrocephalus, documentation of any head injury or concussion is very important.

NEBULIZER

SCHOOL PERSONNEL WHO CAN APPROPRIATELY PROVIDE CARE OR ASSIST THE STUDENT:

a) Routine, nonmedicated and nonoxygenated nebulizer mist: School nurse, RN, LPN, certified personnel, physical therapist, and occupational therapist.

b) Nebulizer — PRN, with oxygen or with medication: School nurse, RN, LPN.

CONSULTATION:

Those responsible for providing care, training and supervision may need to obtain consultation from their clinical supervisor or from other health care providers in the community.

DELEGATION DECISION:

By the school nurse.

TRAINING AND SUPERVISION:

To be determined/provided by the school nurse.

CIRCUMSTANCES WHICH REQUIRE SCHOOL NURSE ACTION:

If routine, nonmedicated and nonoxygenated nebulizer mist is delegated to personnel other than licensed nurses, the nurse must initiate the procedure and remain available in the building. The school nurse should be notified whenever there is evidence of respiratory distress or obstruction.

REMARKS:

Requires prescription from the physician and parent/guardian permission.
If a student requires routine nebulizer treatment **without** medication or oxygen (for humidity only), the school nurse **may** delegate this treatment to certified personnel, or a physical or occupational therapist, when appropriate.
Student and parent/guardian can inform school personnel of procedures used at home.
Parent/guardian provides equipment and supplies.
Consider availability of alternate power source.

Definition:

Nebulize means to convert a liquid to a fine spray.
Mechanical nebulizer is a device powered by either oxygen or compressed air that produces a stable aerosol of fluid particles.
Ultrasonic nebulizer is a device with fluid in a chamber that is vibrated rapidly causing the fluid to break down into small particles which are then carried by a flow of compressed air or oxygen to the student.

Purpose:

To improve breathing by the administration of bronchodilators, mucolytics or other medications directly into the lungs by means of aerosol instillation; to provide an atmosphere of high humidity to assist the break up of pulmonary and bronchial secretions and aid the student in coughing them up.

Equipment: Air compressor or oxygen, oxygen nipple adapter, connection tubing, mechanical nebulizer manifold or ultrasonic nebulizer with cup and mask, medication or saline solution, suction equipment.

Documentation: Document the use of the nebulizer on the student's medication record or treatment log. Any alteration in the student's status or health care plan should be documented by the school nurse on the student's health record.

SPIROMETER
(assisting deep breathing)

SCHOOL PERSONNEL WHO CAN APPROPRIATELY PROVIDE OR ASSIST THE STUDENT:
School nurse, RN, LPN, physical therapist, occupational therapist, teacher, teacher aide, school health aide, other certified personnel.

CONSULTATION:
Those responsible for providing care, training and supervision may need to obtain consultation from their clinical supervisor or from other health care providers in the community.

DELEGATION DECISION:
By the school nurse.

TRAINING AND SUPERVISION:
To be determined/provided by the school nurse.

CIRCUMSTANCES WHICH REQUIRE SCHOOL NURSE:
Any signs of respiratory distress or deterioration in the student's status.

REMARKS:
Requires prescription from the physician and parent/guardian permission.
Equipment is supplied by the family.

Definition:	**Spirometer** means an instrument for measuring the volume of air entering and leaving the lungs.
Purpose:	To encourage achievement of maximum sustained inspiration and thus prevent or treat atelectasis (noninflation of the lung).
Equipment:	Incentive spirometer with mouthpiece and tubing.
Documentation:	Document use of spirometer on the student's health record or treatment log. Any alteration in the student's status or health care plan should be documented by the school nurse on the student's health record.

CONTINUOUS OXYGEN: PER MASK/PER CANNULA

SCHOOL PERSONNEL WHO CAN APPROPRIATELY PROVIDE CARE OR ASSIST THE STUDENT:

a) Initiation of oxygen: School nurse, RN, LPN.
b) Monitoring of oxygen: School nurse, RN, LPN, physical therapist, occupational therapist, teacher, teacher aide, school health aide and other certified personnel.

CONSULTATION:

Those responsible for providing care, training and supervision may need to obtain consultation from their clinical supervisor or from other health care providers in the community.

DELEGATION DECISION:

By the school nurse. If monitoring of oxygen administration is delegated to unlicensed personnel, the school nurse must be in the building.

TRAINING AND SUPERVISION:

To be determined/provided by the school nurse.

CIRCUMSTANCES WHICH REQUIRE SCHOOL NURSE ACTION:

Problems with oxygen delivery, change in student's health or respiratory status, or change in environment.

REMARKS:

Requires nursing review, new prescription from the physician and new parent/guardian permission every three months.
Community or home care team, student and parent/guardian can inform school personnel of procedures used at home.
Equipment must be maintained regularly, and checked daily by the nurse.
Consider fire hazard in relation to smoking or flame in the environment.
Consider storage of equipment in relation to fire, tampering and theft.
Family to provide equipment and supplies for oxygen administration and for moving the oxygen.

Definition:

Mask is usually a clear plastic device that fits snugly over the student's nose and mouth or tracheostomy for the delivery of oxygen at high percentages and to administer medication.
Nasal cannula is a clear plastic tube which fits around the head with two protruding outlets used to deliver oxygen.
Trans-tracheal oxygen is a relatively new procedure employing a clear plastic catheter inserted through a small surgical opening directly into the trachea which uses lower oxygen flow and provides improved oxygenation. Additional information is available from the respiratory therapist and/or the physician.

Pressure gauge/flow meter is a unit that regulates gas pressure to ensure that a manageable pressure is delivered to the student.

Purpose: To assist the student's respirations by relieving hypoxemia (reduced oxygen tension in arterial blood) and hypoxia (reduced oxygen availability to tissue cells) and to deliver medication directly to the respiratory system.

Equipment: Student's oxygen source (gas cylinder, liquid oxygen reservoir, oxygen concentrator), reduction gauge, flow meter, humidifier with distilled water (if ordered), tubing, mask or cannula, mobile stand and back-up oxygen source and equipment.

Documentation: Document administration of oxygen on the student's health record or treatment log. Any alteration in the student's status or health care plan should be documented by the school nurse on the student's health record.

INTERMITTENT OXYGEN: PER MASK/PER CANNULA

SCHOOL PERSONNEL WHO CAN APPROPRIATELY PROVIDE CARE OR ASSIST THE STUDENT:
School nurse, RN, or LPN.

CONSULTATION:
Those responsible for providing care, training and supervision may need to obtain consultation from their clinical supervisor or from other health care providers in the community.

SUPERVISION:
To be determined/provided by the school nurse.

CIRCUMSTANCES WHICH REQUIRE SCHOOL NURSE ACTION:
Problems with oxygen delivery, change in student's health or respiratory status, or change in environment.

REMARKS:
Requires nursing review, prescription from the physician and new parent/guardian permission every three months.
Community or home care team, student and parent/guardian can inform school personnel of procedures used at home.
Consider fire hazard in relation to smoking or flame in the environment.
Equipment must be maintained regularly and checked daily by the nurse.
Consider storage of equipment in relation to fire, tampering and theft.
Family to provide equipment and supplies for the oxygen and for moving the oxygen.
Health care plan must specify individual student parameters for use; that is, it must specify the conditions for initiating and discontinuing oxygen for the individual student.

Definition:

Mask is usually a clear plastic device that fits snuggly over the student's nose and mouth or tracheostomy for the delivery of oxygen at high percentages and to administer medication.

Nasal cannula is a clear plastic tube which fits around his/her head with two protruding outlets used to deliver oxygen.

Trans-tracheal oxygen is a relatively new procedure employing a clear plastic catheter inserted through a small surgical opening directly into the trachea which uses lower oxygen flow and provides improved oxygenation. Additional information is available from the respiratory therapist and/or the physician.

Pressure gauge/flow meter is a unit that regulates gas pressure to ensure that a manageable pressure is delivered to the student.

Purpose: To assist the student's respirations by relieving hypoxemia (reduced oxygen tension in arterial blood) and hypoxia (reduced oxygen availability to tissue cells) and to deliver medication directly to the respiratory system.

Equipment: Student's oxygen source (gas cylinder, liquid oxygen reservoir, oxygen concentrator), reduction gauge, flow meter, humidifier with distilled water (if ordered), tubing, mask or cannula, mobile stand and back-up oxygen source and equipment.

Documentation: Document administration of oxygen on the student's health record or treatment log. Any alteration in the student's status or health care plan should be documented by the school nurse on the student's health record.

ORAL SUCTIONING

SCHOOL PERSONNEL WHO CAN APPROPRIATELY PROVIDE CARE OR ASSIST THE STUDENT:

a) ORAL CAVITY ONLY: School nurse, RN, LPN, physical therapist, occupational therapist, teacher, teacher aide, school health aide, other certified personnel.
b) OROPHARYNGEAL CAVITY: School nurse, RN, LPN.

CONSULTATION:

Those responsible for providing care, training and supervision may need to obtain consultation from their clinical supervisor or from other health care providers in the community.

DELEGATION DECISION:

By the school nurse. Oropharyngeal suctioning cannot be delegated to unlicensed persons.

TRAINING AND SUPERVISION:

To be determined/provided by the school nurse.

CIRCUMSTANCES WHICH REQUIRE SCHOOL NURSE ACTION:

Respiratory distress; difficulty swallowing or vomiting; oral suctioning has never been needed previously; or suctioning beyond the oral cavity is indicated.

REMARKS:

Parent/guardian to provide equipment and supplies.
Physician's order recommended for routine use.

Definition: **Oral** means of or pertaining to the mouth. **Suctioning** is a method of removing fluid from an area by vacuum. **Oral suctioning** is the removal of fluid from the **mouth** (oral cavity) by vacuum. **Oropharyngeal suctioning** is the removal of fluid from the mouth and throat by vacuum.

Purpose: To maintain an open airway through the mouth by removing excess secretions; to stimulate the cough reflex. Suctioning is only indicated when secretions are audible in the airway, or there are signs of airway obstruction or oxygen deficit.

Equipment: Bulb syringe, DeLee Trap or portable suction machine, suction catheter with vent, connecting tube, clean or sterile container for water or saline, sterile water or saline, tissues, sterile or clean towel, paper bag, disposable gloves, plastic-lined trash container.

Documentation: Document oral suctioning on the student's health status record or treatment log. Any alteration in the student's status or health care plan should be documented by the school nurse on the student's health record.

TRACHEOSTOMY CARE AND SUCTIONING

SCHOOL PERSONNEL WHO CAN APPROPRIATELY PROVIDE CARE OR ASSIST THE STUDENT:
School nurse, RN, LPN.

CONSULTATION:
Those responsible for providing care, training and supervision may need to obtain consultation from their clinical supervisor or from other health care providers in the community.

DELEGATION DECISION:
By the school nurse (to the LPN).

TRAINING AND SUPERVISION:
To be determined/provided by the school nurse. The school nurse must be present in the building when care is provided by an LPN (regardless of employer).

CIRCUMSTANCES WHICH REQUIRE SCHOOL NURSE ACTION:
Whenever suctioning is required (unless another licensed nurse is with the student); evidence of respiratory distress, bright red bleeding, tracheostomy tube displacement or skin breakdown. **When the student does not require a private duty nurse*, a school nurse must be in the building at all times.** If the student has a private duty nurse, the school nurse should confer with her daily and PRN to remain current.

REMARKS:
*At times, a student will not require one-on-one (private duty) nursing care (e.g., student rarely or infrequently needs suctioning, coughs effectively to clear airway and is unlikely to require emergency intervention). In this instance, other school personnel may **monitor** the student (observe for respiratory changes, communicate with the school nurse, and initiate emergency care if required). Personnel delegated **monitoring** responsibility (certified personnel, therapists, and/or transportation, teacher and health aides) **must be trained** to initiate CPR, suction and/or reinsert the tracheostomy tube until a licensed nurse or other emergency health professional is available.** **Monitoring** of a student with a tracheostomy is **not delegated** when the student's health status is unstable or the student requires frequent suctioning, has difficulty clearing the airway, or is likely to require emergency intervention.

Students who require care and/or suctioning during transportation should be accompanied by a licensed nurse; those who do not require care or suctioning must be accompanied by an adult (not the driver) **trained to respond to an **unexpected** emergency.

An extra tracheostomy set with obturator, ties, ambu bag and correct size DeLee Trap must be with the student **at all times**. The school should have a battery-operated back-up suction machine and catheter.
Requires prescription from the physician and parent/guardian authorization.
Parent/guardian provides equipment and supplies.

Definition:	**Tracheostomy** is a surgical opening into the trachea through the neck to facilitate breathing. **Tracheostomy tube** is a single or double-walled cannula (tube) of metal or plastic inserted through the tracheostomy stoma (opening) and held in place with ties around the neck. **Suctioning** is the act or process of removing fluid or solids by mechanical suction from the student's airway.
Purpose:	To maintain an open airway by keeping the cannula clear of secretions and exudate; to prevent infection; to minimize irritation of tissue around the stoma.
Equipment:	See individual protocol.
Documentation:	Document tracheostomy care and suctioning on the student's health record or treatment log. Any alteration in the student's status or health care plan should be documented by the school nurse on the student's health record.

POSTURAL DRAINAGE

SCHOOL PERSONNEL WHO CAN APPROPRIATELY PROVIDE CARE OR ASSIST THE STUDENT:
School nurse, RN, LPN, physical therapist.

CONSULTATION:
Those responsible for providing care, training and supervision may need to obtain consultation from their clinical supervisor or from other health care providers in the community.

DELEGATION DECISION:
By the school nurse (to the LPN).

SUPERVISION:
School nurse will supervise LPN.

CIRCUMSTANCES WHICH REQUIRE SCHOOL NURSE ACTION:
Any signs of respiratory distress or deterioration in the student's status or if medication is required with the procedure.

REMARKS:
Requires prescription from the physician and parent/guardian permission.

Definition:	**Postural drainage** means positioning the human body in prescribed postures that facilitate removal of secretions from the lungs by gravity.
Purpose:	To supplement the action of the respiratory muscles to produce an effective cough and thus rid the airway of excessive, thick or sticky mucus.
Equipment:	Pillows, tissues, emesis basin, plastic-lined waste container, suction equipment (if needed), slant board, wedge or folding cot if needed.
Documentation:	Document postural drainage on the student's health record or treatment log. Any alteration in the student's status or health care plan should be documented by the school nurse on the student's health record.

PERCUSSION

SCHOOL PERSONNEL WHO CAN APPROPRIATELY PROVIDE CARE OR ASSIST THE STUDENT:
School nurse, RN, LPN, physical therapist.

CONSULTATION:
Those responsible for providing care, training and supervision may need to obtain consultation from their clinical supervisor or from other health care providers in the community.

DELEGATION DECISION:
By the school nurse (to the LPN).

SUPERVISION:
School nurse will supervise LPN.

CIRCUMSTANCES WHICH REQUIRE SCHOOL NURSE ACTION:
Any signs of respiratory distress or deterioration in the student's status or if medication is required with the procedure.

REMARKS:
Requires prescription from the physician and parent/guardian permission.

Definition:	**Percussion** means to briskly clap or pat the chest using a cupped hand with relaxed and flexed wrists thus producing a hollow sound but no pain.
Purpose:	To help loosen secretions lodged in the airway.
Equipment:	A halved and padded bulb from an asepto syringe (if needed) for small child.
Documentation:	Document percussion on the student's health record or treatment log. Any alteration in the student's status or health care plan should be documented by the school nurse on the student's health record.

CARE OF INCONTINENT STUDENT

SCHOOL PERSONNEL WHO CAN APPROPRIATELY PROVIDE CARE OR ASSIST THE STUDENT:
School nurse, RN, LPN, physical therapist, occupational therapist, teacher, teacher aide, school health aide, other certified personnel.

CONSULTATION:
Those responsible for providing care, training and supervision may need to obtain consultation from their clinical supervisor or from other health care providers in the community.

DELEGATION DECISION:
By the school nurse.

TRAINING AND SUPERVISION:
To be determined/provided by the school nurse.

CIRCUMSTANCES WHICH REQUIRE SCHOOL NURSE ACTION:
Evidence of skin breakdown, infection or rash.

REMARKS:
Parent/guardian to provide clean clothes and personal supplies.
This procedure should be done **minimally** twice during a regular school day or more frequently as determined in the individualized health care plan.
Determine if a bowel or bladder training program is appropriate for the student. If so, see procedure for prescribed bowel and bladder training.

Definition:	An **incontinent** student is one who is unable to control the passage of urine or feces (stool).
Purpose:	To keep the student as clean and dry as possible; to prevent skin breakdown and subsequent infection; to improve the student's acceptance by his school peers.
Equipment:	Incontinence pads (such as Attends), bedpan and urinal, soap and water, wash cloth and towel, clean clothing, plastic bag for soiled clothing, plastic-lined waste container, toilet tissue, disposable gloves, diapers when age appropriate.
Documentation:	Document the care of incontinent student on the student's health record or treatment log. Any alteration in the student's status or health care plan should be documented by the school nurse on the student's health record.

BEDPAN AND URINAL

SCHOOL PERSONNEL WHO CAN APPROPRIATELY PROVIDE CARE OR ASSIST THE STUDENT:
School nurse, RN, LPN, physical therapist, occupational therapist, teacher, teacher aide, school health aide, and other certified personnel.

CONSULTATION:
Those responsible for providing care, training and supervision may need to obtain consultation from their clinical supervisor or from other health care providers in the community.

DELEGATION DECISION:
By the school nurse.

TRAINING AND SUPERVISION:
To be determined/provided by the school nurse.

REMARKS:
Parents will supply equipment, as needed.
Infection control technique is mandatory.

BEDPAN PROCEDURE

Definition: **Bedpans and urinals** are metal, ceramic or plastic receptacles for collecting the urine and/or bowel movements of a person who is unable to use a toilet or commode.

Purpose: To assist a student with regular evacuation of bowel and bladder.

Equipment: Disposable gloves, warm bedpan, bedpan cover, bell or call system, toilet paper, equipment for handwashing, cot protector, newspaper to protect the furniture.

Documentation: Document use of bedpan and urinal on the student's health record or treatment log. Any alteration in the student's status or health care plan should be documented by the school nurse on the student's health record.

BOWEL AND BLADDER TRAINING PROGRAMS

SCHOOL PERSONNEL WHO CAN APPROPRIATELY PROVIDE CARE OR ASSIST THE STUDENT:
School nurse, RN, LPN, physical therapist, occupational therapist, teacher, teacher aide, school health aide, other certified personnel.

CONSULTATION:
Those responsible for providing care, training and supervision may need to obtain consultation from their clinical supervisor or from other health care providers in the community.

DELEGATION DECISION:
By the school nurse. Medication by rectal route cannot be delegated.

TRAINING AND SUPERVISION:
To be determined/provided by the school nurse.

CIRCUMSTANCES WHICH REQUIRE SCHOOL NURSE ACTION:
Evidence of skin breakdown, rash, infection, or change in medical prescription; medication administration (rectal); evaluation of the student's progress.

REMARKS:
Parent/guardian will provide personal supplies and medications, if prescribed.
A training program may be initiated by the parent, school personnel or the student's health care provider.
A physician's order is required when medication will be used.

Definition: **Bowel and bladder training programs** are individually designed to regularly and consistently aid the student to become continent.

Purpose: To establish or re-establish continence; to minimize complications from incontinence or poor bladder and bowel habits; to foster developmentally appropriate toilet skills; to foster the student's independence and acceptance by his/her peers.

Equipment: Varies with the individual health care plan.

Documentation: Document bowel and bladder training programs on the student's health record or treatment log. Any alteration in the student's status or health care plan should be documented by the school nurse on the student's health record.

EXTERNAL CATHETER

SCHOOL PERSONNEL WHO CAN APPROPRIATELY PROVIDE CARE OR ASSIST THE STUDENT:
School nurse, RN, LPN, teacher, physical therapist, occupational therapist, teacher aide, school health aide and other certified personnel.

CONSULTATION:
Those responsible for providing care, training and supervision may need to obtain consultation from their clinical supervisor or from other health care providers in the community.

DELEGATION DECISION:
By the school nurse.

TRAINING AND SUPERVISION:
To be determined/provided by the school nurse.

CIRCUMSTANCES WHICH REQUIRE SCHOOL NURSE ACTION:
The school nurse should be notified if there is evidence of skin breakdown.

REMARKS:
May require physician prescription and parent/guardian permission.
Parent/guardian will supply necessary equipment.

Definition:	**External** means outside or exterior. **Catheter** is a flexible tube to introduce or remove fluid. **External catheter** can be a condom type urinary collection device, vinyl rolled or with jock-type supporter for males or special device or pouch for females.
Purpose:	To maintain social continence (clothing dry and/or free from odor); to obtain a urine specimen.
Equipment:	Collection device with urinary drainage bag (leg bag), soap and water, disposable gloves, nonadhesive, self-adherent elastic tape (e.g., coban tape or a "memory strip" adhesive or brand that family uses for condom catheters).
Documentation:	Document external catheter care on the student's health record or treatment log. Any alteration in the student's status or health care plan should be documented by the school nurse on the student's health record.

CLEAN INTERMITTENT CATHETERIZATION

SCHOOL PERSONNEL WHO CAN APPROPRIATELY PROVIDE CARE OR ASSIST THE STUDENT:
School nurse, RN or LPN.

CONSULTATION:
Those responsible for providing care, training and supervision may need to obtain consultation from their clinical supervisor or from other health care providers in the community.

DELEGATION DECISION:
By the school nurse.

TRAINING AND SUPERVISION:
To be determined/provided by the school nurse.

CIRCUMSTANCES WHICH REQUIRE SCHOOL NURSE ACTION:
Evidence of change in urine consistency; color or odor; unusual pain; inability to insert catheter; or allergic symptoms.

REMARKS:
Requires prescription from the physician and parent/guardian authorization.
Parent/guardian provides equipment and supplies.
Allergy to rubber products (including catheters, gloves and balloons) in children with Myelodysplasia (Spina Bifida) is not uncommon. Symptoms range from rash and urticaria at the contact site to watery eyes, wheezing and respiratory distress.
If the student can perform self-catheterization, the school nurse can delegate general supervision of this procedure to a physical therapist, occupational therapist, teacher, teacher aide, school health aide or other certified personnel.

Definition: **Clean intermittent catheterization** is the periodic emptying of urine from the bladder by means of a straight catheter (rubber, plastic, metal or glass) using clean, but not sterile, technique.

Purpose: To remove urine from the bladder; to maintain renal and bladder health; to decrease the frequency of urinary tract infections; to provide social continence; to establish a bladder training program; to avoid the use of an indwelling catheter; to foster independence, and to maintain skin integrity.

Equipment: Catheter (as prescribed by physician); water soluble lubricating jelly (if ordered); cotton balls; 4x4s or towelettes; container for urine (if needed); storage containers for catheters (marked clean and dirty); storage container for supplies; plastic-lined waste container; mirror for teaching; disposable gloves. Plastic sterile disposable catheters are available (e.g., "Mentor SELF-CATH") and are ideal for use in school.

An ileal conduit sampling catheter is designed to obtain an uncontaminated urine specimen from a student with a urinary diversion.

Documentation: Document clean intermittent catheterization on the student's health record or treatment log. Any alteration in the student's status or health care plan should be documented by the school nurse on the student's health record.

STERILE INTERMITTENT CATHETERIZATION

SCHOOL PERSONNEL WHO CAN APPROPRIATELY PROVIDE CARE OR ASSIST THE STUDENT:
School nurse, RN, LPN.

CONSULTATION:
Those responsible for providing care, training and supervision may need to obtain consultation from their clinical supervisor or from other health care providers in the community.

DELEGATION DECISION:
By the school nurse.

SUPERVISION:
To be determined/provided by the school nurse.

REMARKS:
Requires prescription from the physician and parent/guardian authorization.
Parent/guardian provides equipment and supplies.

Definition:	**Sterile intermittent catheterization** is the periodic emptying of urine from the bladder by means of a straight catheter, using sterile technique.
Purpose:	To remove urine from the bladder; to maintain renal and bladder health; to decrease the frequency of urinary tract infections; to provide social continence; to establish a bladder training program; to avoid the use of an indwelling catheter; to obtain a urine specimen.
Equipment:	A sterile catheterization set including sterile gloves, forceps, sterile lubricant, collection tray, sterile cotton balls, drape, betadine or antiseptic solution, sterile catheter of prescribed size (if sterile catheter is not included in tray) and some protective pads.
Documentation:	Document sterile intermittent catheterization on the student's health record or treatment log. Any alteration in the student's status or health care plan should be documented by the school nurse on the student's health record.

EXTERNAL CARE OF INDWELLING CATHETER

SCHOOL PERSONNEL WHO CAN APPROPRIATELY PROVIDE CARE OR ASSIST THE STUDENT:
School nurse, physical therapist, occupational therapist, teacher, teacher aide, school health aide, other certified personnel.

CONSULTATION:
Those responsible for providing care, training and supervision may need to obtain consultation from their clinical supervisor or from other health care providers in the community.

DELEGATION DECISION:
By the school nurse.

TRAINING AND SUPERVISION:
To be determined/provided by the school nurse.

CIRCUMSTANCES WHICH REQUIRE SCHOOL NURSE ACTION:
The school nurse must be notified if there is any evidence of infection, pain, skin breakdown, displacement or obstruction of the catheter, bleeding, or a change in urine consistency, color or odor.

REMARKS:
Parent/guardian must provide supplies and equipment.
May require prescription from physician and parent permission.

Definition:	**An indwelling catheter** or retention catheter is inserted into the bladder to provide urinary drainage over a period of time from hours to weeks. It is attached to a closed drainage and collection system.
Purpose:	To empty the bladder of urine as it accumulates; to minimize residual urine; to decrease incidence of bladder infection; to control incontinence.
Equipment:	Urinary collection system as ordered.
Documentation:	Document external care of indwelling catheter on the student's health record or treatment log. Any alteration in the student's status or health care plan should be documented by the school nurse on the student's health record.

REINSERTION OF INDWELLING URINARY CATHETER

(urethral and suprapubic)

SCHOOL PERSONNEL WHO CAN APPROPRIATELY PROVIDE CARE OR ASSIST THE STUDENT:
School nurse or RN only.

CONSULTATION:
Those responsible for providing care, training and supervision may need to obtain consultation from their clinical supervisor or from other health care providers in the community. The school nurse must consult with the student's physician to determine whether a displaced urinary catheter needs to be reinserted immediately.

SUPERVISION:
To be determined/provided by the school nurse.

CIRCUMSTANCES WHICH REQUIRE SCHOOL NURSE ACTION:
In a particular circumstance, nursing assessment may indicate that reinsertion of the catheter requires physician evaluation, such as when displacement is traumatic, (i.e., frank bleeding or swelling is present) or when reinsertion is difficult. It is recommended that the same size catheter be reinserted, or as close a size as possible. If reinsertion is difficult, or the decision is made not to replace the catheter, make sure the student is diapered or protected from soiling himself/herself or his/her clothing. A dry dressing may be used to cover a urinary stoma.

REMARKS:
Physician's order and parent/guardian permission is required.
Parent/guardian must provide necessary equipment and supplies.

Definition: An **indwelling urinary catheter** is a plastic, rubber or stylastic tube held in place by a balloon inside the bladder in order to empty the bladder of urine or irrigate the bladder. An indwelling catheter is allowed to remain in place so that the student can be socially continent (clothing dry and free of odor). Urethural catheters are passed through the urethra into the bladder for the withdrawal of urine. A **supra-pubic tube** is a catheter passed through a stoma in the supra-pubic area (above the pubic

arch) into the bladder for the withdrawal of urine. If the catheter falls out or is accidentally pulled out, a new tube needs to be reinserted. In the case of a supra-pubic tube, the tube should be replaced as soon as possible or at least within two hours.

Purpose: To empty the bladder of urine, irrigate the bladder and keep the student clean and dry. To maintain the patency of the stoma in the student with a supra-pubic tube.

Equipment: Sterile foley catheter, size as ordered by physician; two 10 cc syringes; 1" wide paper or nonallergic waterproof tape; two 10 cc bottles of saline; 4x4 gauze; scissors; water soluble lubricant; sterile cotton balls; emesis basin or urinal; mineral oil; damp wash cloths; soapy water; sterile gloves; disposable gloves; and clamp/plug or hemostat. Additional equipment for supra-pubic tube reinsertion includes Q-tips and half-strength hydrogen peroxide.

Documentation: Document reinsertion of an indwelling urinary catheter on the student's health record or treatment log. Any alteration to the student's status or health care plan should be documented by the school nurse on the student's health record.

Assisted Ambulation: CRUTCHES, WALKER, CANE

SCHOOL PERSONNEL WHO CAN APPROPRIATELY ASSIST THE STUDENT:
School nurse, RN, LPN, physical therapist, occupational therapist, teacher, teacher aide, school health aide, other certified personnel.

CONSULTATION:
Those responsible for providing care, training and supervision may need to obtain consultation from their clinical supervisor or from other health care providers in the community.

DELEGATION DECISION:
By the school nurse and/or physical therapist.

TRAINING AND SUPERVISION:
To be determined/provided by the school nurse and/or physical therapist.

CIRCUMSTANCES WHICH REQUIRE SCHOOL NURSE OR PHYSICAL THERAPIST ACTION:
Initial teaching of gait pattern; evidence of adverse reaction or effects from ambulation or use of appliances; change in student performance; change in physician's order.

REMARKS:
Requires a physician's order and parent/guardian permission.
During the initial phases of rehabilitation following trauma or surgery, assistance with ambulation will not be delegated.
Parents provide equipment and supplies.

Definition:	**Crutches, walkers or canes** are supports used as aids in walking or to prevent full weight bearing on one or both legs.
Purpose:	To promote mobility and independence; to prevent injury to an affected limb.
Equipment:	As ordered.
Documentation:	Document assisted ambulation on the student's health record or treatment log. Any alteration in the student's status or health care plan should be documented by the school nurse on the student's health record.

POSITIONING

SCHOOL PERSONNEL WHO CAN APPROPRIATELY PROVIDE CARE OR ASSIST THE STUDENT:
School nurse, RN, LPN, physical therapist, occupational therapist, teacher, teacher aide, school health aide, other certified personnel.

CONSULTATION:
Those responsible for providing care, training and supervision may need to obtain consultation from their clinical supervisor or from other health care providers in the community.

DELEGATION DECISION:
By the school nurse and/or physical therapist/occupational therapist.

TRAINING AND SUPERVISION:
To be determined/provided by the school nurse and/or physical therapist/occupational therapist.

CIRCUMSTANCES WHICH REQUIRE SCHOOL NURSE/THERAPIST ACTION:
Evidence of skin breakdown; pain during or after positional changes; any change in the student's health status.

REMARKS:
May require physician's order and parent/guardian permission.

Definition: **Positioning** means adjusting, placing, turning, lifting and moving the student, or assisting the student into an optimal position.

Purpose:
1. To support the student in order to promote maximal educational benefit.
2. To maximize visual skills and vertical orientation.
3. To promote weight bearing and sensory stimulation.
4. To decrease abnormal muscle tone by considering tonic neck reflexes.
5. To encourage postural control against gravity.
6. To make the student comfortable.
7. To improve respiration and circulation.
8. To prevent complications from immobility.

Equipment: Chairs, standers (prone and supine), bolsters, wedges, mats, hydraulic lifts.

Documentation: Document the student's position on the student's health record or treatment log. Any alteration in the student's status or health care plan should be documented by the school nurse on the student's health record.

TRANSFERS

SCHOOL PERSONNEL WHO CAN APPROPRIATELY PROVIDE CARE OR ASSIST THE STUDENT:
School nurse, RN, LPN, physical therapist, occupational therapist, teacher, teacher aide, school health aide, other certified personnel.

CONSULTATION:
Those responsible for providing care, training or supervision may need to obtain consultation from their clinical supervisor or from other health care providers in the community.

DELEGATION DECISION:
By the school nurse in consultation with the physical/occupational therapist.

TRAINING AND SUPERVISION:
To be determined/provided by the school nurse and/or physical/occupational therapist.

CIRCUMSTANCES WHICH REQUIRE SCHOOL NURSE/THERAPIST ACTION:
Initial teaching of technique; evidence of adverse effects in student or staff; change in physician order (if applicable); any change in the student's health status.

REMARKS:
May require physician's order regarding weight-bearing activities.
Parents provide equipment, if applicable.

Definition:

Stand pivot transfer — The student stands and turns to sit in another seat. Weight may be borne fully or partially on one or both legs. Physical assistance, if needed, may be given by one or two persons.

Sliding board transfer — A board* is used to span the gap between two raised surfaces/seats. The student remains in a sitting position and moves across the board. This technique is usually used by students who do not stand.

Purpose: To move from one seat/surface to another.

Equipment: * Sliding boards come in various shapes and lengths. They are usually made of wood.

Documentation: Document transfers, when indicated, on the student's health record or treatment log. Any alteration in the student's status or health care plan should be documented by the school nurse on the student's health record.

RANGE OF MOTION

SCHOOL PERSONNEL WHO CAN APPROPRIATELY PROVIDE CARE OR ASSIST THE STUDENT:
School nurse, RN, LPN, physical therapist, occupational therapist, teacher.

CONSULTATION:
Those responsible for providing care, training and supervision may need to obtain consultation from their clinical supervisor or from other health care providers in the community. Since, in most situations, the registered physical therapist or occupational therapist are best qualified to perform the assessment and develop the initial management plan, the school nurse may need to consult with the appropriate therapist.

DELEGATION DECISION:
To be determined by the school nurse in consultation with the physical therapist/ occupational therapist, as appropriate.

TRAINING AND SUPERVISION:
To be determined/provided by the school nurse/physical therapist/occupational therapist.

CIRCUMSTANCES WHICH REQUIRE SCHOOL NURSE/THERAPIST ACTION:
Relevant change in student's health status; pain; alteration in joint mobility.

REMARKS:
May require prescription from the physician and parent/guardian permission.
If the program is prescribed by a physician, it should be carried out by the nurse or therapist.

Definition: **Range of Motion** means to exercise a joint to the extent of its range in all appropriate directions. **Passive** range of motion exercises are done ***for*** the student. **Active** range of motion exercises are done ***by*** the student. **Assistive** range of motion exercises are done by the student with help from an individual or an assistive device. **Resistive** range of motion exercises are done by the student against a weight-opposing pressure.

Purpose: To keep the joints flexible; to minimize joint deformity and limitation; to increase circulation; to improve muscle tone; to improve functional skills.

Using a communication board, computer or switch may increase a student's spasticity and make this activity progressively more difficult. Some intermittent relaxation and stretching may be beneficial. Gross positional changes may also be carried out in a safer, more comfortable manner if some joint or limb preparation is included.

Equipment: A Goniometer is used to measure joint range of motion.

Documentation: Document range of motion exercises on the student's health record or treatment log. Any alteration in the student's status or health care plan should be documented by the school nurse on the student's health record.

ASSIST WITH CLOTHING

SCHOOL PERSONNEL WHO CAN APPROPRIATELY PROVIDE CARE OR ASSIST THE STUDENT:
School nurse, RN, LPN, physical therapist, occupational therapist, teacher, teacher aide, school health aide, other certified personnel.

CONSULTATION:
Those responsible for providing care, training and supervision may need to obtain consultation from their clinical supervisor or from other health care providers in the community.

DELEGATION DECISION:
By the school nurse and/or physical/occupational therapist, as appropriate.

TRAINING AND SUPERVISION:
To be determined/provided by school nurse/physical therapist/occupational therapist, as appropriate.

CIRCUMSTANCES WHICH REQUIRE SCHOOL NURSE OR THERAPIST ACTION:
The school nurse may not delegate this task when the student is at significant risk for injury during the procedure.

REMARKS:
Student and parent may inform school personnel of procedure used at home.
Procedures should be designed to maximize the student's independence.

Purpose:	To assist and support the student in managing his/her clothing, to help him/her toward independence in activities of daily living, and to prevent injury to students who are neurologically or orthopedically fragile.
Equipment:	Clothing that is clean, dry, not restrictive, comfortable, soft to the skin, appropriate to climate and season, safe, attractive, simple in design, easy to care for, practical and appropriate for student's condition. Dressing Tools: recommended tools may include a reacher, long-handled shoe horn, elastic shoelaces, button aid, dressing stick and a mirror.
Documentation:	Document on the student's health record or treatment log. Any alteration in the student's status or health care plan should be documented by the school nurse on the student's health record.

BRACES (ORTHOSES) AND PROSTHESES
(donning, doffing, weaning into)

SCHOOL PERSONNEL WHO CAN APPROPRIATELY PROVIDE CARE OR ASSIST THE STUDENT:
School nurse, RN, LPN, physical therapist, occupational therapist, teacher, teacher aide, school health aide, other certified personnel.

CONSULTATION:
Those responsible for providing care, training and supervision may need to obtain consultation from their clinical supervisor or from other health care providers in the community.

DELEGATION DECISION:
By the school nurse and/or physical therapist/occupational therapist.

TRAINING AND SUPERVISION:
To be determined/provided by the school nurse/physical therapist/occupational therapist, as appropriate.

CIRCUMSTANCES WHICH REQUIRE SCHOOL NURSE ACTION:
Changes in skin integrity, evidence of skin breakdown, infection or rash.

REMARKS:
May require a physician's order and parent/guardian permission.

Definition: A **brace** is an appliance used to improve function or support a body part; an orthosis.
A **prosthesis** is an artificial body part that functions as a replacement — usually a limb.

Purpose: To protect weakened muscles; to prevent and correct deformities; to contain involuntary muscle movements; to immobilize and protect a diseased or injured joint.

Documentation: Document on the student's health record or treatment log. Any alteration in the student's status or health care plan should be documented by the school nurse on the student's health record.

BLOOD SAMPLE
Hemoglobin/Hematocrit (finger stick)

SCHOOL PERSONNEL WHO CAN APPROPRIATELY PROVIDE CARE OR ASSIST THE STUDENT:
School nurse, RN, LPN.

CONSULTATION:
Those responsible for providing care, training and supervision may need to obtain consultation from their clinical supervisor or from other health care providers in the community.

DELEGATION DECISION:
By the school nurse.

SUPERVISION:
To be determined/provided by the school nurse.

REMARKS:
Requires a physician's order or school policy for health screening.
Requires parent/guardian permission.
Use universal precautions.

Definition:	**Blood sample by finger stick** is capillary blood obtained by skin puncture.
Purpose:	To obtain a sample of the student's blood for testing/screening.
Equipment:	Sterile disposable blood lancet or automatic lancet, alcohol swab or appropriate disinfectant, dry sterile 2x2s, disposable gloves, sharps container and plastic-lined waste container.
Documentation:	Document blood sample on the student's health record or treatment log. Any alteration in the student's status or health care plan should be documented by the school nurse on the student's health record.

BLOOD GLUCOSE MONITORING

SCHOOL PERSONNEL WHO CAN APPROPRIATELY PROVIDE CARE OR ASSIST THE STUDENT:
School nurse, RN and LPN.

CONSULTATION:
Those responsible for providing care, training and supervision may need to obtain consultation from their clinical supervisor or from other health care providers in the community.

DELEGATION DECISION:
By the school nurse.

TRAINING AND SUPERVISION:
To be determined/provided by the school nurse.

CIRCUMSTANCES WHICH REQUIRE SCHOOL NURSE ACTION:
Any change in student's baseline health status or as specified in the students health care plan.

REMARKS:
Requires physician's order and parent/guardian permission.
Parent/guardian provide supplies/equipment.

Definition:	**Blood glucose monitoring** is the procedure used to determine a student's blood glucose level. **A blood glucose monitor** is a device to measure the student's blood glucose level.
Purpose:	To evaluate diabetes control; to adjust insulin dosage and nutritional intake.
Equipment:	Sterile disposable blood lancet or automatic lancet, alcohol swab or appropriate disinfectant, dry sterile 2x2s, disposable gloves, sharps container and plastic-lined waste container. Blood glucose monitor (as prescribed) with manufacturer's instructions.
Documentation:	Document blood glucose monitoring on the student's health record or treatment log. Any alteration in the student's status or health care plan should be documented by the school nurse on the student's health record.

MAINTENANCE AND CARE OF EQUIPMENT

SCHOOL PERSONNEL WHO CAN APPROPRIATELY CARE FOR EQUIPMENT:
All school personnel using the equipment or assigned responsibility for maintenance/care of the equipment.

CONSULTATION:
Those responsible for providing care, training and supervision may need to obtain consultation from their clinical supervisor or from other health care providers in the community.

RESPONSIBILITY:
1. For all nursing/medical equipment that is either school property or is student owned: the school nurse will be responsible for ensuring proper **in-school** care/maintenance and identifying training needs for any school personnel involved in the care of equipment.
2. For all equipment that is either school property or student owned and that is utilized primarily by occupational therapist/physical therapist/teacher or other school staff (such as snidefoot orthoses, wheelchairs): the occupational therapist/physical therapist/teacher will be responsible for ensuring proper **in-school** care/maintenance and identifying training needs for any school personnel involved in the care of equipment.

REMARKS:
Follow current nursing procedures and recommendations of manufacturer/home care provider. Parents are responsible for cleaning and maintenance of all equipment that comes with the student to school.

Definition: **Care of** implies looking after or dealing with something or someone. **Equipment** is something material, such as an instrument, apparatus, or thing, which is required for a particular treatment, purpose or job.

Purpose: To ensure that equipment will function when needed by the student for routine care or in an emergency; to minimize risk of infection from equipment shared by several students; and to reduce risk of infection from repeated use of equipment by same student.

Documentation: Document maintenance and care of equipment on the student's health record or equipment maintenance log.

DOCUMENTATION

SCHOOL PERSONNEL WHO CAN APPROPRIATELY DOCUMENT HEALTH CARE SERVICES:

School nurse, RN and LPN and other licensed health professionals. Unlicensed certified and non-certified school personnel may assist the health professionals in documenting health services.

Documentation should demonstrate collaborative and coordinated student care and communication with the family. In instances where the physical therapist, occupational therapist or speech therapist is responsible for the care provided, the therapist will determine the need for documentation and/or the type of documentation and should coordinate such documentation with the school nurse. Whenever possible, all health professionals should use a single system for documentation of student progress. Such collaboration enhances student care.

CONSULTATION:

Those responsible for providing care, training and supervision may need to obtain consultation from their clinical supervisor or from other health care providers in the community.

DELEGATION DECISION:

The decision to delegate documentation of health care services is made by the school nurse. Documentation on the Cumulative Health Record is usually not delegated except that the nurse may delegate copying of routine screening/immunization data to an appropriately trained designee.

TRAINING AND SUPERVISION:

To be determined/provided by the school nurse.

CIRCUMSTANCES WHICH REQUIRE SCHOOL NURSE ACTION:

Documentation on the Cumulative Health Record; documentation on nursing progress notes and nursing record; access to the cumulative health record; access to the nursing progress notes and nursing record; access to medical records maintained in the health room; any change in the student's status.

REMARKS:

See Hahn, K. in Bibliography. This article describes a multidisciplinary model for collaborative care and documentation adaptable to school settings.

Definition: Documentation is the preparing or assembling of written records to authenticate the health care that is provided and the reasons for providing that care. Nursing documentation includes accurate records of nursing assessment of the student's health status; medical diagnoses; nursing diagnoses, collaborative problems and related educational issues; the individualized health care plan (IHCP) based on established goals; nursing and collaborative interventions; evaluation of the effectiveness of the plan; subsequent reassessment and revisions in the health care plan; the physician orders; and parent authorization.

Purpose: To promote high quality, coordinated health services for students; to facilitate application of the scientific process (also called the "nursing process") to nursing assessment and interventions; to foster communication and consistency of care among health service providers; to ensure accountability; to provide a tool for quality assurance; to substantiate the level of care provided for legal purposes; and to furnish data for education, research and third-party reimbursement, when appropriate.

Equipment: Student's cumulative health record; student's nursing record and progress notes; other confidential or third-party health records; medication or treatment logs; other documentation forms; and pen.

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* Indicates current clinical nursing references.

APPENDIX A

EXCERPTS FROM RELEVANT PRACTICE ACTS OF HEALTH PROFESSIONALS LICENSED IN THE STATE OF CONNECTICUT

I. Medicine and Surgery: C.G.S. Chapter 370

Sec. 20-8a. (a) There shall be within the department of health services a Connecticut medical examining board....

(e) ....Said board shall (1) hear and decide matters concerning suspension or revocation of licensure, (2) adjudicate complaints against practitioners and (3) impose sanctions where appropriate.

Sec. 20-9. Who may practice medicine or surgery: No person shall, for compensation, gain or reward, received or expected, diagnose, treat, operate for/or prescribe for any injury, deformity, ailment or disease, actual or imaginary, of another person, nor practice surgery, until he has obtained such a license as provided in section 20-10, and then only in the kind or branch of practice stated in such license; but the provisions of this chapter shall not apply to dentists while practicing dentistry only; nor to any person in the employ of the United States government while acting in the scope of his employment; nor to any person who furnished medical or surgical assistance in cases of sudden emergency; nor to any person rendering service as an advanced practice registered nurse if such service is rendered under the direction of a licensed physician; nor to any nurse-midwife practicing nurse-midwifery in accordance with the provisions of chapter 377, nor to any podiatrist licensed in accordance with the provisions of chapter 375; nor to any Christian Science practitioner who does not use or prescribe in his practice any drugs, poisons, medicines, chemicals, nostrums or surgery; ....nor to any person rendering service as a physician assistant licensed pursuant to section 20-12b, a registered nurse, or a licensed practical nurse if such service is rendered under the supervision, control and responsibility of a licensed physician; nor to any person performing athletic training as described in section 19a-16a, except that this section shall not authorize anyone to practice optometry as defined in chapter 380 or to practice dentistry or dental hygiene as defined in chapter 379; ....

Sec. 20-14. Exceptions.... Penalties: ...Any person who violates any provision of section 20-9 shall be fined not more than five hundred dollars or be imprisoned not more than five years or be both fined and imprisoned. For the purposes of this section, each instance of patient contact or consultation which is in violation of any provision of section 20-9 shall constitute a separate offense. Failure to renew a license in a timely manner shall not constitute a violation for the purposes of this section. Any person who swears to any falsehood in any statement required by section 20-10, 20-12, 20-12b or 20-12c to be filed with the department of health services shall be guilty of false statement.

II. Physical Therapists: C.G.S. Chapter 376

Sec. 20-66. Definitions. As used in this chapter:

(1) "Physical therapist" means a person licensed to practice physical therapy in Connecticut as defined in subdivision (2) of this section;

(2) "Physical therapy" means the evaluation and treatment of any person by the employment of the effective properties of physical measures, the performance of tests and

measurements as an aid to evaluation of function and the use of therapeutic exercises and rehabilitative procedures, with or without assistive devices, for the purpose of preventing, correcting or alleviating a physical or mental disability. Physical therapy" does not include the use of cauterization or the use of Roentgen rays or radium for diagnostic or therapeutic purposes; and

(3) "Physical therapist assistant" means a graduate of a physical therapist assistant program licensed by the Connecticut board of governors for higher education or approved by the American Physical Therapy Association or other professional accrediting association approved by the United States Department of Education and recognized by the commissioner of health services.

Sec. 20-68. Meetings. Powers and duties of board, its members and department of health services: .... Said board shall (1) hear and decide matters concerning revocation or suspension of licensure, (2) adjudicate complaints against practitioners and (3) impose sanctions where appropriate.

Sec. 20-73. Use of title "Registered Physical Therapist" or "Licensed Physical Therapist". Fraud in obtaining registration. Practice regulated. Revocation of license: No person who is not licensed by the department of health services as a physical therapist shall practice or hold himself out as authorized to practice physical therapy as defined in section 20-66, or represent himself as being so registered or licensed or use in connection with his name the term "Registered Physical Therapist", "Licensed Physical Therapist" or "Physical Therapist" or the letters "R.P.T.", "L.P.T." or any other letters, worlds or insignia indicating or implying that he is a licensed physical therapist in this state. The treatment of human ailments by physical therapy shall only be performed by a person licensed under the provisions of this chapter as a physical therapist upon the oral or written referral of a person licensed in this state or in a bordering state having licensing requirements meeting the approval of the appropriate examining board in this state to practice medicine and surgery, osteopathy, podiatry, natureopathy, chiropractic or dentistry. Any person who violates the provisions of this section or who obtains or attempts to obtain licensure as a physical therapist by any wilful misrepresentation or any fraudulent representation shall be fined not more than five hundred dollars or imprisoned not more than five years, or both. Any person who violates the provisions of this section shall be subject to revocation of his license in the same manner as is provided under section 20-45 to 20-48, inclusive, or sections 20-13a. For purposes of this section each instance of patient contact or consultation which is in violation of any provision of this section shall constitute a separate offense. Failure to renew a license in a timely manner shall not constitute a violation for the purposes of this section.

Sec. 20-74. Construction: No provision of this chapter shall confer any authority to practice medicine or surgery, nor shall this chapter prohibit the incidental care of the sick by domestic servants or by persons principally employed as housekeepers or as athletic trainers, nor prohibit any person from the domestic administration of family remedies or the furnishing of assistance in the case of emergency. It shall not prohibit persons registered under the provisions of chapter 371, 372, 373, 375 or 378 from administering care to patients, nor shall it prohibit the care of the sick with or without compensation or personal profit in connection with the practice of the religious tenets of any church by adherents thereof, provided such persons shall not otherwise engage in the practice of physical therapy within the meaning of this chapter. . .

III. Occupational Therapists C.G.S. Chapter 376a

Sec. 20-74a. Definitions. As used in this chapter:

(1) "Occupational therapy" means the evaluation, planning and implementation of a program of purposeful activities to develop or maintain adaptive skills necessary to achieve the maximal physical and mental functioning of the individual in his daily pursuits. The practice of "occupational therapy" includes, but is not limited to, evaluation and treatment of individuals whose abilities to cope with the tasks of living are threatened or impaired by developmental deficits, the aging process, learning disabilities, poverty and cultural differences, physical injury or disease, psychological and social disabilities, or anticipated disfunction, using (A) such treatment techniques as task-oriented activities to prevent or correct physical or emotional deficits or to minimize the disabling effect of these deficits in the life of the individual, (B) such evaluation techniques as assessment of sensory motor abilities, assessment of the development of self-care activities and capacity for independence, assessment of the physical capacity for prevocational and work tasks, assessment of play and leisure performance, and appraisal of living areas for the handicapped, (C) specific occupational therapy techniques such as activities of daily living skills, the fabrication and application of splinting devices, sensory motor activities, the use of specifically designed manual and creative activities, guidance in the selection and use of adaptive equipment, specific exercises to enhance functional performance, and treatment techniques for physical capabilities for work activities. Such techniques are applied in the treatment of individual patients or clients, in groups, or through social systems.

(2) "Occupational therapist" means a person licensed to practice occupational therapy as defined in this chapter and whose license is in good standing.

(3) "Occupational therapy assistant" means a person licensed to assist in the practice of occupational therapy, under the supervision of or with the consultation of a licensed occupational therapist, and whose license is in good standing.

Sec. 20-74e. Exempt activities: (a) Nothing in this chapter shall be construed as preventing or restricting the practice, services or activities of: (1) Any person licensed in this state by any other law from engaging in the profession or occupation for which he is licensed; ....

IV. Nursing C.G.S. Chapter 378

Sec. 20-87a. Definition of nursing, advanced nursing practice and practical nursing:

(a) The practice of nursing by a registered nurse is defined as the process of diagnosing human responses to actual or potential health problems, providing supportive and restorative care, health counseling and teaching, case finding and referral, collaborating in the implementation of the total health care regimen and executing the medical regimen under the direction of a licensed physician or dentist.

(b) Advanced nursing practice is defined as the performance of advanced level nursing practice activities which, by virtue of postbasic specialized education and experience, are appropriate to and may be performed by an advanced practice registered nurse. The advanced practice registered nurse performs acts of diagnosis and treatment of alterations in health status, as described in subsection (a) of this section. The advanced practice registered nurse may, under the direction of a physician licensed to practice medicine in this state and in accordance with written protocols, and if practicing in (1) an institution

licensed pursuant to subsection (a) of section 19a-491 as a hospital, home for the aged, health care facility for the handicapped, nursing home, rest home, mental health facility, substance abuse treatment facility, infirmary operated by an educational institution for the care of students enrolled in, and faculty and staff of, such institution, or facility operated and maintained by any state agency and providing services for the prevention, diagnosis and treatment or care of human health conditions, or (2) an industrial health facility licensed pursuant to subsection (h) of section 31-374 which serves at least two thousand employees, or (3) a clinic operated by a state agency, municipality, or private nonprofit corporation, or (4) a clinic operated by any educational institution prescribed by regulations adopted pursuant to section 20-99a, or (5) any other settings that may be prescribed by regulations adopted pursuant to said section, prescribe, dispense, and administer medical therapeutics and corrective measures, ...

(c) The practice of nursing by a licensed practical nurse is defined as the performing of selected tasks and sharing of responsibility under the direction of a registered nurse or an advanced practice registered nurse and within the framework of supportive and restorative care, health counseling and teaching, case finding and referral, collaborating in the implementation of the total health care regimen and executing the medical regimen under the direction of a licensed physician or dentist.

(d) In the case of a registered or licensed practical nurse employed by a home health care agency, the practice of nursing includes executing the medical regimen under the direction of a physician licensed in a state which borders Connecticut.

Sec. 20-88 State Board of Examiners for Nursing: (a) The Connecticut state board of examiners for nursing shall consist of twelve members who are residents of the state to be appointed by the governor subject to the provisions of section 4-09a. . .

Sec. 20-90 Duties of board:
(b) Said board shall (1) hear and decide matters concerning suspension or revocation of licensure, (2) adjudicate complaints filed against practitioners licensed under this chapter and impose sanctions where appropriate.

Sec. 20-94a. Licensure as advanced practice registered nurse: (a) The department of health services may issue an advanced practice registered nurse license to a person seeking to perform the activities described in subsection (b) of section 20-87a, upon receipt of a fee of one hundred dollars, to an applicant who satisfies the following requirement: (1) Is eligible for registered nurse licensure in this state, as provided by section 20-93 or 20-94; (2) holds and maintains current certification as either a nurse practitioner, a clinical nurse specialist, or a nurse anesthetists from one of the following national certifying bodies which certify nurses in advanced practice: The American Nurses' Association, the Nurses' Association of the American College of Obstetricians and Gynecologists Certification Corporation, the National Board of Pediatric Nurse Practitioners and Associates or the American Association of Nurse Anesthetists; (3) has completed thirty hours of education in pharmacology for advanced nursing practice; and (4) if first certified by one of the foregoing certifying bodies after December 31, 1994, holds a masters' degree in nursing or in a related field recognized for certification as either a nurse practitioner, a clinical nurse specialist, or a nurse anesthetist by one of the foregoing certifying bodies. No license shall be issued under this section to any applicant against whom professional disciplinary action is pending or who is the subject of an unresolved complaint.

Sec. 20-101. Permitted practices. ... No provision of this chapter shall confer any authority to practice medicine or surgery nor shall this chapter prohibit any person from the domestic administration of family remedies or the furnishing of assistance in the

case of an emergency. . . This chapter shall not prohibit the care of persons in their homes by domestic servants, housekeepers, nursemaids, companions, attendants or household aides of any type, whether employed regularly or because of an emergency of illness, if such persons are not initially employed in a nursing capacity.

Sec. 20-102. Penalty: No person shall, for remuneration, practice nursing as defined in subsection (a) of section 20-87a, in this state unless such person has received a certificate as a registered nurse or a license as an advanced practice registered nurse and no person shall practice advanced nursing practice as defined in subsection (b) of said section unless such person has received a license as an advanced practice registered nurse and no person shall, for remuneration, practice nursing as defined in subsection (c) of said section unless such person has been certified as a licensed practical nurse or a registered nurse or licensed as an advanced practice registered nurse. Any person who violates any provision of this chapter or who wilfully makes false representation to the board of examiners for nursing shall be fined not more than five hundred dollars or imprisoned for not more than five years or both. Said board shall cause to be presented to the prosecuting officer having jurisdiction evidence of any violation of any such provision. For purposes of this section each instance of patient contact or consultation which is in violation of any provision of this section shall constitute a separate offense. Failure to renew a license in a timely manner shall not constitute a violation for the purposes of this section.

V. Psychologists: C.G.S. Chapter 383

Sec. 20-186a. Duties of board of examiners: The board of examiners of psychologists shall (1) hear and decide matters concerning suspension or revocation of licensure, (2) adjudicate complaints filed against practitioners licensed under this chapter and (3) impose sanctions where appropriate.

Sec. 20-187a. License required. Practice defined: No person shall practice psychology unless he has obtained a license as provided in section 20-188. The practice of psychology means the rendering of professional services under any title or description of services incorporating the words psychologist, psychological or psychology, to the public or to any public or private organization for a fee or other remuneration. Professional psychological services means the application, by persons trained in psychology, of established principles of learning, motivation, perception, thinking and emotional relationships to the assessment, diagnosis, prevention, treatment and amelioration of psychological problems or emotional or mental disorders of individuals or groups, including but not limited to counseling, guidance, psychotherapy, behavior modification and personnel evaluation, with persons or groups in the areas of work, family, school, marriage and personal relationships; measuring and testing of personality, intelligence, aptitudes, emotions, public opinion, attitudes and skills; and research relating to human behavior.

Sec. 20-193. False representation. Penalties: Any person not licensed as provided in this chapter who, except as provided in section 20-195, represents himself as a psychologist or, having had his license suspended or revoked continues to represent himself as a psychologist, or carries on the practice of psychology as defined in sections 20-187a and 20-188, shall be fined not more than five hundred dollars or imprisoned not more than five years or both, and each instance of patient contact or consultation which is in violation of this section shall be deemed a separate offense. Failure to renew a license in a timely manner shall not constitute a violation for the purposes of this section. Any such person shall be enjoined from such practice by the superior court upon application by the board. The department of health services may, on its own initiative or at the request of the board, investigate any alleged violation of the provisions of this chapter or any regulations adopted hereunder.

Sec. 20-194. Right to practice medicine not granted: Nothing in this chapter shall be construed to grant to licensed psychologists the right to practice medicine as defined in section 20-9.

Sec. 20-195. Exempted activities and employment: (a) . . .Nothing in this chapter shall be construed to prevent physicians, osteopaths, optometrists, chiropractors, members of the clergy, attorneys-at-law or social workers from doing work of a psychological nature consistent with accepted standards in their respective professions.

(b) Nothing in this chapter shall prevent any person holding a certificate as school psychologist or school psychological examiner, granted by the state board of education, from using such title to describe his activities within an elementary or secondary school. Nothing in this chapter shall prevent any person who holds a standard certificate, granted by said board, as school psychologist or school psychological examiner from using such title to describe his activities within the private sector. Such activities within the private sector shall be limited to: (1) Evaluation, diagnosis, or test interpretation limited to assessment of intellectual ability, learning patterns, achievement, motivation, or personality factors directly related to learning problems in an educational setting; (2) short-term professional advisement and interpretive services with children or adults for amelioration or prevention of educationally-related problems; (3) educational or vocational consultation or direct educational services to schools, agencies, organizations or individuals, said consultation being directly related to learning problems; and, (4) development of educational programs such as designing more efficient and psychologically sound classroom situations and acting as a catalyst for teacher involvement in adaptations and innovations. Section 10-145b and regulations adopted by the state board of education concerning revocation of a standard certificate shall apply to a school psychologist or school psychological examiner who uses such title to describe activities within the private sector.

(c) Nothing in this chapter shall prevent any person employed by the state prior to July 1, 1985, with a title in the psychology series of the classified service from using a title in such series to describe his or her duties in the course of his or her employment with the state. The provisions of section 20-187a shall not apply to any person employed in such psychology series prior to July 1, 1985.

Sec. 20-407. Penalty: Any person who violates any provision of this chapter shall for each offense be fined not more than five hundred dollars or be imprisoned for not more than ninety days or both.

V. Independent Social Workers: C.G.S. Chapter 383b

Sec. 20-195m. Definitions. As used in subsection (c) of section 19a-14, section 19a-18, sections 20-195n to 20-195n to 20-195q, inclusive, and this section.

(a) "Certified independent social worker" means a person who has been certified pursuant to sections 20-195n and 20-195o . . .

Sec. 29-195q. Use of Title. (a) No persons, except those certified under sections 20-195n and 20-195o, shall (1) use the title "certified independent social worker" or any initials associated with such titles, or (2) advertise services under the description of a certified independent social worker as defined in section 20-195m.

(b) The provisions of subsection (c) of section 19a-14, section 19a-18, sections 20-195m to 20-195p, inclusive, and this section shall not restrict the employment of any person who renders social work services for a recognized educational institution, a federal

state or municipal institution, a community action agency, as defined in section 17a-635, or any other institution, facility or agency providing social services.

VI. Speech Pathologists and Audiologists: C.G.S. Chapter 399

Sec. 20-408: Definitions. As used in this chapter, unless the context otherwise requires:

(1) "The practice of speech pathology" means the application of principles, methods and procedures for the measurement, testing, diagnosis, prediction, counseling or instruction relating to the development and disorders of speech, voice or language for the purpose of diagnosing, preventing, treating, ameliorating or modifying such disorders and conditions in individuals or groups of individuals.

(2) "Licensed speech pathologist" means a person licensed under this chapter to practice speech pathology.

(3) "The practice of audiology" means the application of principles, methods and procedures of measurement, testing, appraisal, prediction, consultation, counseling and the determination and use of appropriate amplification related to hearing and disorders of hearing, for the purpose of modifying communicative disorders involving speech, language, auditory function or other aberrant behavior related to hearing loss.

(4) "Licensed audiologist" means a person licensed under this chapter to practice audiology.

Sec. 20-410. License required: On or after July 1, 1974, no person shall engage in or offer to engage in the practice of speech pathology or audiology or represent himself as a speech pathologist or audiologist in this state unless he is licensed or exempted under the provisions of this chapter.

APPENDIX B

NURSING CARE IN THE SCHOOL SETTING: REGULATORY IMPLICATIONS

Today's schools provide a great deal more than instruction. Historically, the traditional role of the school nurse was limited to such activities as providing first aid, performing routine screening, and occasionally running mass immunization programs aimed at school aged children and adolescents.

In recent years the role has expanded considerably. The increasing complexity of the school nurse role mirrors the increasing complexity of society and of the health care system. As a result of those societal changes, children may require nursing interventions for a wide variety of bio-psychosocial problems that were not apparent on their initial entry into school.

The developmental and interpersonal benefits derived by chronically ill and disabled students who participate in the traditional educational setting have been acknowledged. In addition, legal decisions have affirmed the right of all students to a public education that occurs in the least restrictive setting possible. As a result, disabled and chronically ill students have been "mainstreamed" into classroom/schools that may be ill-equipped to meet their needs. Whereas formerly many students who required complex care and who had specialized health care needs would have been privately tutored, they are now mainstreamed into classrooms with students needing less complex care. An increased demand for nursing care to meet the needs of those students has resulted.

The role of the school nurse in health screening programs has expanded and become more complex as has the decision making required when student health records are reviewed. In addition, school nurses serve as consultants to educational staff and provide health teaching to large numbers of students located in multiple settings. As a consequence, registered nurses often do not provide services directly in all of the schools under their supervision and jurisdiction. They may utilize licensed practical nurses and unlicensed personnel (e.g., health aides, teacher's aides, etc.) to provide direct care. In those instances, the direct care is delegated by the registered nurse who retains responsibility for that care and for the supervision of the individuals to whom the care is delegated. In assuming responsibility for the care of students in school settings, including delegation and supervision, the school nurse must follow the regulations included in the Nurse Practice Act, as well as other applicable laws, in the jurisdictions in which they are practicing.

Specifically, RNs who delegate nursing acts must adhere to the delegation requirements and guidelines of the jurisdiction in which they are practicing. The role of Boards of Nursing is to provide guidance to school nurses regarding the delivery of care in the school setting to ensure the health and safety of students. To fulfill this role, boards may refer to the Concept Paper on Delegation (National Council, 1990) as well as their own jurisdictional interpretations regarding requirements for the delegation of nursing tasks.

Nursing Care in the School Setting: Regulatory Implications. National Council of State Boards of Nursing, Inc./1991. Reprinted with permission.

In addition, it is recommended that policies and procedures be developed to guide the educational preparation and practice of school nurses, and that those policies and procedures specifically address delegation and supervision issues. Consideration also needs to be given to the development of protocols for action in specific situations, including the identification of the qualifications of individuals who are authorized to initiate and implement those protocols. Finally, it is recommended that school districts consider establishing maximum student/nurse ratios; such ratios should take into consideration the health needs of the student population being served, the availability of licensed practical nurses and unlicensed personnel to provide direct services, and the need to assure adequate supervision of those individuals. Administrative personnel in school districts should consider their own liability in observing and supporting safe nurse/student ratios.

Where policies, procedures and protocols are established to guide nursing practice in school settings, it is imperative that school nurses be involved in their development.

With the proliferation of specialties in nursing practice, school nursing must be recognized as one of those specialties. Certification for practice as a school nurse is currently available through the National Board for Certification of School Nurses; in addition, many board jurisdictions also provide for such certification through state boards of nursing and/or education.

CONCEPT PAPER ON DELEGATION

Purpose

The purpose of the National Council formulating this concept paper is to provide Member Boards a conceptual basis for delegation from a regulatory perspective. It is the position of the National Council that licensed nurses, in accordance with board of nursing requirements, determine the appropriateness of delegating acts from their scopes of practice. Each person involved in the delegation process is accountable for his/her own actions in this process. There is potential liability if competent, safe care is not the outcome of the delegation.

Premises

1. Performance of non-nurse delegated and non-nurse supervised nursing activities by unlicensed persons constitutes practicing nursing without a license and is not in the interest of the health, safety and welfare of the public.
2. Pieces of care cannot be provided in isolation by unlicensed persons functioning independently of the nurse if the health, safety and welfare of the public is to be assured.
3. Boards of nursing need to work to assure evidence of adequate nurse involvement where nursing services are being provided and delegated.
4. Boards should promulgate clear rules for delegation in all settings where nursing care is delivered.
5. Boards need to clearly define delegation in regulation.
6. A limited supply of nurses must not be used as an excuse for inappropriate delegation to unlicensed persons.
7. Regulations regarding the delegation of nursing functions must be linked to the disciplinary process.
8. Boards need to pursue criminal prosecution when there is clear evidence that unlicensed persons are performing nursing activities not delegated by nurses.

   Premises 1-8 from 1987 "Position Statement on Nursing Activities of Unlicensed Persons."

9. While tasks and procedures may be delegated, the functions of assessment, evaluation and nursing judgement should not be delegated.
10. While non-nurses may suggest which nursing acts may be delegated, it is the licensed nurse who ultimately decides the appropriateness of delegation.
11. The unlicensed person cannot redelegate a delegated act.
12. Boards of nursing must develop clear rules on determination of competence of persons to perform delegated nursing tasks or procedures, the level of supervision necessary, and which acts may be delegated.

Concept Paper on Delegation. National Council of State Boards of Nursing, Inc./1990. Reprinted with permission.

Definitions

Delegation
Transferring to a competent individual authority to perform a selected nursing task in a selected situation.

Delegator
The person making the delegation.

Delegate
The person receiving the delegation.

Supervision
"Provision of guidance by a qualified nurse for the accomplishment of a nursing task or activity with initial direction of the task or activity and periodic inspection of the actual act of accomplishing the task or activity. Total nursing care of an individual remains the responsibility and accountability of the nurse." 1987 "Position Statement on Activities of Unlicensed Persons."

Liability
As used in this paper, the term is limited to the regulatory accountability of a licensee to the licensing agency. Other types of liability (i.e. civil liability) are beyond the scope of this paper.

Background

In 1987, the Nursing Practice and Standards (NP&S) Committee developed a "Statement on the Nursing Activities of Unlicensed Persons." (1987 Statement) The Statement presented an overview of the following: 1) use of unlicensed persons to deliver nursing care since the early 1900s; 2) a rationale for board of nursing involvement in the oversight of activities of unlicensed persons; 3) documentation on the frequency and nature of the use of unlicensed persons; 4) operational definitions of key terms used in describing the frequency and nature of the use of unlicensed persons; and 5) conclusions for Member Board consideration in the state-by-state discussion of the frequency and nature of the use of unlicensed persons. The position statement was adopted by the August 1987 Delegate Assembly and has received wide acclaim, distribution and discussion by the nursing and health care community.

In 1989, the Nursing Practice and Education Committee identified a need for further study of this topic and developed this statement on delegation.

Regulatory Perspective - A Framework for Managerial Policies

Nursing is defined in a statutory mandate which requires an individual to have a license to practice. Two nurse roles (RN/LPN) exist and, though there is a legal relationship between the two, each is held accountable for carrying out its role. RNs may delegate professional nursing acts to LPNs and unlicensed persons. LPNs may, in some jurisdictions, delegate acts within the scope of the practice of practical nursing to unlicensed persons. The statutory mandate may also set forth requirements for supervision when nursing acts are delegated. Boards of nursing should provide guidance regarding which acts may or may not be delegated by the nurse. Direction must be

provided by boards of nursing regarding supervision, including the proximity of the supervising nurse to the delegate. The nurse who delegates an act to another assumes responsibility for the supervision of the act, whether the nurse is physically present or not.

Nurses traditionally carry out the role of nurse in an employment context and act as agents of the employer. The relationship is complex and is usually carried out in a setting in which the employer controls the nature of both the work of the nurse and the circumstances of the nurse role enactment. The licensed nurse is responsible to the employer for employment activities. The licensed nurse is accountable to the board of nursing for nursing practice.

Though employers vary greatly in approaches to nursing care delivery, there are issues for the nurse that are common to all management styles. Those issues center on four common areas of concerns:

1. Who determines the degree of allocation of resources, both human and fiscal?
2. Where does the focus of decision-making related to allocation of resources rest?
3. What level of supervision is required by the employer for the enacting of the role of nurse?
4. What control does the nurse have in determining the nature of the work and the setting/conditions of the work?

Employers of nurses are equally concerned about these issues, but primarily from a management context. It is understandable that there are different approaches by employers and nurses themselves related to these four major concerns and the overall issue of delegation and supervision. Numerous scenarios may develop as a result of different perspectives on delegation and supervision. The employer as the hiring agent is primarily responsible for allocation of all resources. Therefore, policies requiring working in any setting based on organizational need is something that appears reasonable in a managerial context. From a regulatory context, however, assignment to a practice area without current competence creates concern about client safety and welfare that is even more critical. The managerial understanding is that the nurse is hired to carry out a specific role on behalf of the employer and that the employer has the authority to assign the nurse as desired. The regulatory perspective holds the nurse accountable for all nursing actions. The licensed nurse has a responsibility not to accept an assignment which the nurse is unable to perform safely. It is important to distinguish the uncomfortable situation where a nurse is expected to work in an unfamiliar setting within the nurse's usual area of practice from the unsafe situation where a nurse is expected to work in a new setting, outside the nurse's usual area of practice, without adequate orientation, education and supervision.

The regulatory perspective should serve as a framework for managerial policies related to the employment and utilization of nurses. Employers may attempt to require nurses to delegate, especially when faced with staffing problems. This is inappropriate when the nurse is not willing to delegate. While employers and administrators may suggest which nursing acts should be delegated and to whom the delegation may be made, it is the nurse who ultimately decides and who is accountable for deciding whether the delegation occurs. If the nurse decides that the delegation may not appropriately or safely take place, then the nurse should not engage in such delegation. In fact, if the nurse decides that delegation may not appropriately or safely take place, but nevertheless delegates, he/she may be disciplined by the board of nursing.

Acceptable Use of the Authority to Delegate
The decision to delegate should be based on the following:

- Determination of the task, procedure or function that is to be delegated.
- Staff available.
- Assessment of the client needs.
- Assessment of the potential delegate's competency.
- Consideration of the level of supervision available and a determination of the level and method of supervision required to assure safe performance.

Nurses should avoid delegating practice pervasive functions of assessment, evaluation and nursing judgment. Sometimes there is a differentiation made between the terms "delegation" and "assignment." Delegation involves giving to someone else a task from the delegator's practice. Assignment involves giving to someone else a task within his/her own practice. Based upon this differentiation, the RN would assign acts to other RNs who have the same scope of practice. The RN would delegate to others, e.g., LPNs and unlicensed persons, acts which are within the scope of professional nursing practice. Similarly, the LPN would assign acts within the scope of practice of practical nursing to other LPNs. However, the LPN would, if allowed under the State Nurse Practice Act, delegate practical nursing acts to unlicensed persons.

Licensure Accountability
Every nurse is accountable as an individual for practicing according to the statutory mandate in the nurse's jurisdiction of practice. The delegating nurse is accountable for assessing the situation and is responsible for the decision to delegate. Monitoring, outcome evaluation and follow-up are necessary supervisory activities that follow delegation. The delegator is accountable for the act delegated, and may incur liability if found to be negligent in the process of delegating and supervising.

The delegate is accountable for accepting the delegation and for his/her own actions in carrying out the act. If licensed, this person may incur liability if he/she deviates from safe practice through no fault of the delegating nurse.

Boards of nursing may review situations where a delegating nurse made an acceptable delegation to a competent delegate who erred in the performance of the delegated act. Clearly, the delegate is accountable for his/her actions in performing the delegated act. The delegator would be expected to provide supervisory follow-up such as intervention on behalf of the client and corrective action. The delegator would be accountable for the delegation and supervision provided.

Conclusion

From a regulatory perspective, the nurse is held accountable for both acts directly carried out and acts delegated. This regulatory perspective should serve as the framework for managerial policies related to the employment and utilization of nurses. Where nurse practice acts permit, RNs and LPNs may delegate certain acts within their respective practices. They may be involved in either delegation or assignment, depending upon interpretation of the definitions of these terms. Both the delegating nurse and delegate are accountable for their own actions in the delegation process. Furthermore, the delegating nurse has a responsibility to determine that the delegate is indeed competent to perform the delegated act. Finally, the delegating nurse must provide appropriate supervision. The nurse must be the person who ultimately decides when and under what circumstances delegation is to occur. Non-nursing and managerial persons must not coerce the nurse into compromising client safety by requiring the nurse to delegate. While tasks and procedures may be delegated, the nurse should not delegate practice pervasive functions of assessment, evaluation and nursing judgment.

National Council of State Boards of Nursing, Inc./1990

APPENDIX C

DEFINITIONS

Accountability	State of being responsible, answerable, or legally liable for action. Health professionals are accountable for all delegated tasks or functions.
Certification	The process by which a state or organization authorized by a state government provides a credential to individuals. The process by which a health professional receives recognition from a national certifying body for competence or expertise in a specialty practice area.
Chronic Condition	A physical, physiologic and/or developmental impairment; any anatomical or physiological impairment that interferes with the individual's ability to function in the environment.
Chronic Health Condition	One that is long term and is either not curable or has residual features that result in limitations in daily living requiring special assistance or adaptation in function.
Chronic Illness	A condition that interferes with daily functioning for more than 3 months in a year, causes hospitalization of more than 1 month in a year, or (at time of diagnosis) is likely to do either of these.
Delegation (Nursing)	The process of entrusting the performance of selected nursing tasks to competent licensed or unlicensed persons in selected situations.
Delegation (Medical)	The process of entrusting the performance of selected medical tasks to competent licensed individuals in selected situations.
Developmental Disability	Any severe, chronic disability that is attributable to a mental and/or physical impairment, is manifested before age 22 years, is likely to continue indefinitely, results in substantial limitation of function and requires special services.
Diagnosis	The careful, critical study of something in order to determine its nature.
Disability	The functional limitations imposed by, and the psychological response resulting from, an impairment.

Educational Setting	Any setting in which the student receives instruction, whether school building, institution, or home.
Emergency	A serious situation that arises suddenly and threatens the life or welfare of a person; a crisis.
Free Appropriate Public Education	Special education and related services provided at public expense, which meet state education agency standards and are consistent with the student's individualized education program.
Health Aide (Nurse's Aide)	A person who is qualified to carry out basic, specialized health care procedures in the care of students under the supervision of a registered professional nurse.
Health Assessment	As used in these guidelines, the collection and analysis of information or data about a student's health situation to determine the student's state of health, patterns of functioning and needs for health services, counseling and education. Health assessment is the licensed function of physicians and nurses.
Handicap	An environmental barrier preventing or making it difficult for full participation or integration, such as curbs or steps for someone in a wheelchair; the social consequences of an impairment and resulting disability that interferes with social role fulfillment.
Health Professional	Individual with specialized educational preparation, knowledge and skill who is licensed or certified to provide **specific** health care services to clients, such as nurses, physicians, occupational and physical therapists, speech language pathologists, clinical psychologists, and social workers.
HBV	Hepatitis B Virus, the causative agent of Hepatitis B infection.
HIV	Human Immune Virus, the causative agent of AIDS.
Impairment (Health)	Any chronic illness, disability, developmental disability or terminal illness, whether physical or mental in nature.
Individualized Health Care Plan	A plan of action to be used by the school nurse and other members of the school team, as appropriate, to meet the health needs of a student.
In-service Education	Instructional programs that provide for continuing professional growth and development of all school personnel.
Judgment	The process of forming an opinion or evaluation of a situation arrived at by reasoning, discerning and comparing premises or general principles.

Knowledge	Understanding, familiarity or awareness acquired through science, art, technique and experience where known fact, ideas and skill have been applied.
Least Restrictive Environment	A requirement, that to the maximum extent possible, children with disabilities are educated with non-disabled children. Removal of children with disabilities from the regular educational environment occurs only when the nature or severity of the disability is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily.
Licensed Practical Nurse (LPN)	An individual who is licensed to function as a practical nurse in Connecticut. LPNs must work under the direction of a registered nurse (RN).
Licensure	Permission by a competent authority (usually a governmental agency) to an organization or individual to engage in a practice or activity, usually granted on the basis of education and examination. Licensure of health professionals in Connecticut is regulated through the Department of Health Services.
Medication	Any over-the-counter or prescription drug.
Multidisciplinary Team	Individuals representing family, education, health and school administration who have assessed the student and/or will provide direct or indirect services to the student.
Nurse	Generic term referring to a person licensed to practice nursing.
Nurse Practice Act	A statute enacted by the legislature of any state or by the appropriate officers of the districts or possessions. The act delineates the legal scope of the practice of nursing within the geographical boundaries of its jurisdiction.
Nursing	The practice of nursing by a **registered nurse** (RN) is defined as the process of diagnosing human responses to actual or potential health problems, providing supportive and restorative care, health counseling and teaching, case finding and referral, collaborating in the implementation of the total health care regimen and executing the medical regimen under the direction of a licensed physician or dentist. (C.G.S. Sec. 20-87a.)

Advanced nursing practice is defined as the performance of advanced level nursing practice activities which, by virtue of postbasic specialized education and experience, are appropriate to and may be performed by an **advanced practice registered nurse**. (C.G.S. Sec. 20-87a). Advanced nursing practice includes the ordering of diagnostic tests to determine medical diagnoses and the prescription of medical therapeutics, including medication, and corrective measures under mutually agreed upon protocols with a directing physician.

The practice of nursing by a **licensed practical nurse** (LPN) is defined as the performing of selected tasks and sharing of responsibility under the direction of a registered nurse or an advanced practice registered nurse and within the framework of supportive and restorative care, health counseling and teaching, case finding and referral, collaborating in the implementation of the total health care regimen and executing the medical regimen under the direction of a licensed physician or dentist. (C.G.S. Sec. 20-87a.)

Nursing Diagnosis — A statement that describes the human response of an individual or group to actual or potential health problems. Nursing diagnoses are those which the nurse can legally identify and for which the nurse can order definitive interventions to maintain the health state or to reduce, eliminate or prevent alterations.

Other Health Impaired — A categorical label for special education eligibility which refers to "a child with limited strength, vitality or alertness, due to chronic or acute health problems, which is anticipated to be of more than three weeks' duration" and which adversely impacts educational performance [C.G.S. 10-76a-2(i)].

PRN — As circumstances may require.

Registered Nurse (RN) — An individual who is licensed in Connecticut by the State Department of Health Services to practice nursing. The professional nurse has responsibility for the care of individuals and groups through a colleague relationship with a physician, to function in making self-directed judgments, and to act independently in the practice of the profession.

School Nurse — A registered nurse or nurse practitioner who meets the requirements set forth in Connecticut regulations Sec. 10-212-1 through Sec. 10-212-7.

Skill — The ability to use one's knowledge, judgment and competency effectively and readily in performing a learned psychomotor task.

Special Health Care Needs	Health-related services, supports or adaptations required by a student in order to maintain his/her health status including: medical devices, nursing care, psychosocial care, medically necessary services, specific services and equipment to sustain and enrich life and adaptations required to maintain life, provide an environment conducive to growth and development, stimulate learning and maintain him/her in the least restrictive environment.
Student	Any infant, child or adolescent, age 0 to 21 years, who is planning to enter, or has entered, a school program or other setting where educational services are being provided.
Student with Special Health Care Needs	One who may require technology, health services and/or some other form of health-related support services or program modifications in order to access an appropriate educational program.
Standard of Practice	A standard established by custom or authority as a model, criterion, or rule for comparison or measurement.
Supervision (Nursing)	Provision of guidance by a qualified nurse for the accomplishment of a nursing task or activity with initial direction of the task or activity and periodic inspection of the actual act of accomplishing the task or activity. Total nursing care of an individual remains the responsibility and accountability of the nurse. **General Supervision:** Includes review, observation and evaluation of another's performance by the professional nurse, but does not require the nurse to be present at all times. **Direct Supervision:** Requires the professional nurse to be on-site, physically present and immediately available to coordinate, direct, inspect and evaluate the performance of another.
TB	Tuberculosis.
Technology-Dependent Child	One who has a long-term chronic disability; requires a medical device to sustain life; requires skilled care or monitoring on a routine daily basis; and is 21 years or younger.
Terminal Illness	Any illness, of long or short duration, with a life-threatening outcome.

To Maintain One's Health Status	To stay as healthy and functional as possible; to prevent deterioration in one's condition; to maximize one's ability to develop normally.
Unlicensed Personnel	Staff members who are not authorized (by licensure) to provide health care services or perform health care acts or tasks that are regulated by the State Department of Health Services.

These definitions are taken from a wide variety of sources, primarily nursing and medical literature.

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FOCUS on EXCEPTIONAL children

Providing Education to Students With Complex Health Care Needs

Donna H. Lehr

Ever since enactment of the Education for All Handicapped Children Act (PL 94-142) in 1975, school districts have been opening their doors to students who pose greater and greater challenges to their teachers and administrators. The newest challenge is that of providing education to students with complex health care needs (Sirvis, 1988; Viadero, 1987). There has been a long tradition of providing education to students with chronic illnesses such as diabetes, asthma, spina bifida, sickle cell anemia, hemophilia, cystic fibrosis, and muscular dystrophy (cf. Hobbs, Perrin & Ireys, 1985; Kleinberg, 1982). But typically when those students' conditions progressed to the point that they needed health care services such as catheterization, respiratory therapy, tube feeding ventilation or oxygen, they were hospitalized or remained at home and did not attend school. The school(s) usually made adjustments for their absences or provided home or hospital instruction until their condition improved.

Now students are not automatically removed from schools for prolonged periods when they need complex health care services. After their medical conditions stabilize, students with chronic illnesses or other complex health care needs requiring specialized, skilled care, and possibly medical technology to support them, are coming to today's schools. Schools may have to take measures to ensure that serious communicable diseases are not spread within the school. The special needs student may require apnea monitoring, tube feeding, mechanical or machine suctioning, mechanical ventilation, oxygen, or other health care that is different, and often much more complex, than the schools typically have provided in the past.

Kathy, an 8-year-old student, is an example of such a child currently attending a public school. She was a healthy, normally developing child until age 2, when she wandered out of the family's summer cottage and found her way to the lake, where she nearly drowned. Kathy was in a coma for 4 weeks. Upon discharge from the hospital after regaining consciousness, Kathy was no longer able to walk, talk, or eat by herself.

Kathy has difficulty swallowing and coughing—processes necessary to deal with food and saliva present in her mouth and throat. Consequently, Kathy cannot eat food by mouth, but instead is fed through a tube that enters directly into her stomach. Because she is unable to deal with the build-up of saliva and mucus in her mouth and throat, especially when she gets a cold, those fluids must be removed frequently by use of a suctioning machine. The machine has a long tube that is inserted into her mouth, and into her throat, when necessary, to remove the excessive fluid.

Dr. Lehr is associate professor, Department of Special Education, Boston University. *This article is an adaptation of D.H. Lehr (1990), "Students with Complex Health Care Needs in Today's Schools", in E.L. Meyen (Ed.),* Exceptional Children in Today's Schools *(Denver: Love Publishing Co.)*

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EMERGENCE OF THE NEW POPULATION OF STUDENTS

Students like Kathy are present in increasing numbers in our schools. Why weren't they in the schools before? Among the reasons are technological advances in medicine, greater acceptance of the principle of normalization, an increase in programs for young children and those with severe handicaps (Lehr & Noonan, 1989), and increased group care of children with communicable diseases in schools.

Medical Technology

Improvements in medical technology have had two major consequences for students who have complex health care needs. First, children with serious health conditions are living longer than previously was possible. In the past, many children born prematurely with low birth weight, with congenital birth defects, or who acquired injuries after birth did not survive long enough to become students as they are doing now (Lehr & Noonan, 1989). Now, although they may survive, it is often with continued disabilities, sometimes very severe. The effort to save all children in distress has resulted in more students with severe handicapping conditions.

Improvements in medical technology also have resulted in the development of equipment to monitor and support these children's lives. Much of that equipment is now smaller than in the past, portable, and, in some cases, battery-operated. This enables children to be much more mobile than before. Children previously confined to places with electrical outlets can now move much more freely in their communities—attend picnics, participate in playground activities, and be transported in family cars and school buses, making attendance at school possible.

FOCUS ON EXCEPTIONAL CHILDREN

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The Principle of Normalization

Changes in people's attitudes toward the care of individuals with disabilities also accounts for the increased numbers of individuals with complex health care needs in the schools. In the past, the usual practice was to segregate such individuals from the mainstream of society. Wolfensberger's (1972) principle of normalization called for the most normal environmental routines for all individuals, to obtain the most normal behaviors from the individuals. The philosophy was put into action through the deinstitutionalization movement and through the movement to place individuals with disabilities in the least restrictive placements appropriate to meet their needs. In the field of education, the principle of the least restrictive environment , set forth in PL 94–142, represents an embodiment of this philosophy. The result of all of this is that, now, efforts are being made to place all students, including those with complex health care needs, in the least restrictive, most like normal placement appropriate for each individual student.

Programs for Young Children and Those with Severe Handicaps

The third reason for the increase in numbers of students with complex health care needs in the schools is the increase in programs for very young students. PL 94–142 mandated programs for students to age 5, with incentives for students down to age 3. The 1986 amendment to that law, PL 99–457, mandates programs to age 3 in all states receiving federal funds, and further incentives for providing services to birth. Consequently, we have seen a steady

increase in the number of programs serving young children with handicapping conditions. This young population of children has been the beneficiary of the improved medical technology, and consequently the children who survive with their birth defects but not without continued disabilities or complex health care needs.

PL–94-142 also requires school districts to serve all students including those with the most severe handicaps. This is the population of students that we see in the greatest number of those with accompanying medical needs (Hotte, Monroe, Philbrook, & Scarlata, 1984).

Group Care of Children with Communicable Diseases

Among children with severe handicaps are many who do not have control of body functions and require care such as feeding and toileting or diaper changing. Group care of children who do not control their body functions and who, as all young children do, explore their environment by mouthing things, increases the risks of transmitting contagious diseases unless careful attention is paid to hygienic care of students. Among the diseases of concern are the common cold, as well as more serious diseases such as cytomegalovirus, hepatitis, herpes, and a new concern, HIV infection.

Human immunodeficiency virus (HIV) was simply not known prior to 1982. Now, it is estimated that by 1992 it will be the leading cause of mental retardation and the fifth leading cause of death in children in this country. Although it has not yet become a frequently encountered situation in the schools, it is estimated that approximately 3,000 children in this country will be affected by it by 1991 (Tolsma, 1988). Although the number of students is not large, and the disease is not transmitted through casual contact, public concern over the presence of infected students in the schools and the deadly consequences of infection require careful attention to matters regarding their inclusion in schools.

DEFINITIONS

"Students with complex health care needs" is a term I use to describe a specific, yet heterogeneous population of students. This term may include students who are labeled in the literature as (a) having chronic illnesses, (b) being technology-dependent, or (c) being medically fragile. The term goes beyond that, however, to encompass students whose needs require delivery of education and related services in new ways, different from those traditionally provided in the schools. Use of the term is, I hope, temporary, as service delivery, after a time, is expected to become more usual and not as complex. This is not to say that meeting these students' needs will become easy but, instead, that the issues and practices will become less complex to those involved.

Definitions exist for each of the subgroups comprising this population. Children with chronic illnesses may have "conditions such as burns; trauma from physical injuries that are long standing, such as spinal cord injuries or closed head trauma; and conditions more classically defined and as chronic illnesses, such as asthma, diabetes, cystic fibrosis and cancer" (Kleinberg, 1982, p. 4). They may have "a set of conditions that affects one or more body organs and represents an active disease process. It may last many months or a lifetime" (p. 4).

These students have serious illnesses that may require special health care at some times and not at other times. This can be contrasted with the following definitions of technology-dependent and medically fragile children who require special health care continuously.

The U.S. Congress, Office of Technology Assessment (1987) defines a child who is technology-dependent as:

> . . . one who needs both a medical device to compensate for the loss of a vital body function and substantial and ongoing nursing care to avert death or further disability. (p. 3)

The Office of Technology Assessment report continues its explanation by identifying four populations within this group: (a) children dependent on mechanical ventilators, (b) children requiring nutrition or drugs intravenously, (c) children with the need for daily mechanical respiratory or nutritional support, and (d) children with long-term dependence on mechanical devices such as apnea monitors, renal dialysis and urinary catheters, or colostomy bags.

The Task Force on Technology Dependent Children (1988) has defined a technology-dependent child as one who:

> is a person from birth through 21 years of age; has a chronic disability; requires the routine use of a specific medical device to compensate for the loss of use of a life sustaining body function; and requires daily, ongoing care or monitoring by trained personnel. (p. vii)

The Council for Exceptional Children uses the term "medically fragile" to identify a population of students who "require specialized technological health care procedures for life support and/or health support during the school day" (1988, p. 1).

The last group of students included in this population termed "students with complex health care needs" are those students attending today's schools with serious communicable diseases. Among the diseases referred to are HIV (AIDS), herpes, and hepatitis. Although many other contagious diseases exist, these stand out because of their severe disabling consequences.

CHARACTERISTICS OF STUDENTS WITH COMPLEX HEALTH CARE NEEDS

Students with complex health care needs do not demonstrate a common set of learner characteristics. The group includes students with average or above-average intellectual abilities; but others have accompanying handicapping conditions such as mental retardation or significant neuromotor disabilities (Lehr & Noonan, 1989).

Although students with complex health care needs demonstrate tremendous variability in characteristics, they do share the following needs:

- the need to be provided with a free public educational program
- the need to be provided with an education in the least restrictive environment
- the need to have as a part of their educational program a health care plan
- the need to be treated as a child first, then a student, and not as a patient
- the need to interact with other children with and without similar health care needs.

ISSUES IN PROVIDING EDUCATION TO STUDENTS WITH COMPLEX HEALTH CARE NEEDS

Because the presence of students with complex health care needs in schools is new, many questions arise for which there are no clear answers. No federal guidelines exist, nor are there comprehensive models demonstrating the best practices. Consequently, program administrators are making difficult case-by-case decisions regarding how to serve such children (Lehr & Noonan, 1989). Issues being addressed include:

- health care procedures to be performed in schools
- responsibility for administering the procedures
- preparation for personnel to perform the procedures
- the relationship between educational and health care service provision
- student transportation.

Health Care Procedures Performed in Schools

In the past, students requiring procedures such as tube feeding or suctioning were routinely excluded from school. The zero exclusion principle and the least restrictive principle of PL 94-142 did much to change this automatic placement decision. But considerable variation continues to exist in these decisions. Children with complex health care needs are not automatically excluded from educational programs; however, their placement might be in a hospital, at home, in a segregated school, or in regular school. Some districts' policies are to serve all students with any health care needs necessary, others exclude students who require oxygen or those with communicable diseases such as HIV (AIDS), hepatitis, or herpes.

Responsibility for Administration of Procedures

Another issue is that of who has the responsibility to provide the health care procedures. Does the responsibility belong to the school district or the family, or other health agencies? If the schools have that responsibility, who in the school should perform the procedures? Issues revolve around the question of what is related service and what is a medical service, as defined in PL 94-142.

PL 94–142 specifies that a school district must provide related services including ". . . transportation, and such developmental, corrective, and other supportive services . . . as may be required to assist a handicapped child to benefit from special education" (Section 1401(a)(17)). Medical services are defined as "services provided by a licensed physician to determine a child's medically related handicapping conditions which results in the child's need for special education and related services" (34 CFR Reg 330.13(b)(4).

In *Tatro v. Texas* (1983), the U.S. Supreme Court determined that clean intermittent catheterization procedures were the responsibility of the school district as a related service necessary for the student to benefit from special education. In three other court cases revolving around the provision of health care to students, one led to a decision that the necessary procedures were related services and therefore school district responsibility (*Department of Education, State of Hawaii v. Dorr* 1983). In the other two cases, the health care procedures were considered to be more complex than those typically provided in schools and therefore not the school districts' responsibility (*Detsel v. Ambach*, 1986; *Bevin, H.*, 1986). Clearly, the courts are demonstrating differences of legal opinion regarding what

constitutes related versus medical services in their decision making. Consequently, with the exception on the provision of clean intermittent catheterization, responsibility for other procedures is being decided by each school district.

When a decision is made that the school district is responsible for implementing procedures, the next question becomes: Who in the district is responsible? Tremendous variability exists. A student in one school district may be having his or her needs met by a school nurse, while another student, in a neighboring district, may be cared for by an instructional aide. The primary responsibility for providing school health services to students traditionally has rested on the school nurse. Nurses have the responsibility for establishing policy and procedures, with school administration, for emergency procedures, medication administration protocols, safety measures and programs, student/personnel health services, and health education (American Nurses Association, 1983). Although many health procedures have been carried out by school nurses, some of the students attending today's schools require procedures that are different and sometimes more complex than those routinely provided. One study indicates that school nurses do not believe they are adequately trained to implement many procedures required by students now attending public schools (Hester, Goodwin, & Igoe, 1980).

Further, nurses are not always available to provide the needed health care services. In many elementary schools a school nurse is assigned for as little as one half day per week. Obviously, this is an inadequate amount of time to meet the needs of a student who has to be tube-fed daily or one who requires suctioning hourly. Consequently, classroom teachers are routinely performing such procedures in their classrooms (Mulligan Ault, Guess, Struth, Thompson, 1988). Sirvis (1988) has pointed out, however, that in most cases even the most skilled special education teacher may be hesitant to provide for students with special health care needs.

Personnel Preparation for Service Provision

Even though they often do not feel adequately prepared to implement some of the procedures students require, school nurses, teachers, or aides may be responsible for implementing the procedures. Careful attention is being given to training those involved in the care of this population of students. What training should be provided? Who should provide it? Who should receive the training?

Several organizations are now emphasizing in their recommendations the need for policies regarding training to serve students with special health care needs. For example, the Task Force on Children with Special Health Care Needs in Iowa (1988) makes specific recommendations for both preservice and inservice training of all personnel involved with these children, including teachers, support staff, and even bus drivers.

Student Transportation

Transportation of students to school becomes another difficult decision for program administrators. Some students with special health care needs must come to school attached to their portable life-supporting or sustaining equipment. Some must receive immediate attention in case of medical emergency. The range encompasses students who are transported by family members, students transported by ambulance, and students transported on regular buses. Students are being transported with only the bus driver present or, at the other extreme, with a nurse present. In one case reported, a bus driver, who is alone in accompanying a student to and from school, has been trained to perform mechanical suctioning in the event it becomes necessary (Lehr & Haubrich, 1988).

Combining Education with Care

How the health care procedure will relate to education is another issue of concern. The teacher should view the child as first a child and second as a student, but not as a patient. These are *children* with health care needs. But concern about the child's health care can overshadow educational emphases.

Some students' education may relate specifically to their care needs. It may include instructional priorities related to less resistance or increased participation in their own care. Or it may relate to increased communication regarding care needs. At the same time, the students will have educational needs like those of their peers who do not have health care needs: the need to learn basic skills and knowledge; the need to learn to function as independently as possible, the need to learn to read, write, and do arithmetic. The presence of students with complex health care needs in the schools is causing educators to rethink the definition and purposes of education.

Students with communicable diseases pose some additional questions regarding the combination of education and care. Educational institutions are not accustomed to providing hygienic care for students. Until recently, self-care (toilet training) and self-feeding were prerequisites for

admission into schools. Now students who lack control over their body functions are in schools, and teachers must pay careful attention to all students, but particularly to those with communicable diseases. Hygienic care procedures must become routine and unobtrusive to assure that they do not become the emphasis of, but rather a support to, the educational program.

Staff concern regarding the presence of a student with a communicable disease also may interfere with the delivery of education. The staff must be given information regarding disease transmission, methods for preventing and controlling the spread of diseases when caring for all students. In addition, maintaining confidentially of information and proper education is essential to assure that the child's rights as a citizen are not violated.

Because no definitive federal or state rules are available regarding educational service provision to students with special health care needs (Task Force on Technology Dependent Children, 1988), services provided to those students are variable and inconsistent (Hobbs et al., 1985). Although variations in services are necessary to meet students' individual needs, these differences must be based on the needs of students, not on differences in district administrative resources or interest.

POLICIES FOR SERVING STUDENTS WITH COMPLEX HEALTH CARE NEEDS

The first step in developing consistency of services may be to develop policies. Several groups and organizations have begun to develop recommendations, guidelines, or policies to guide administrators in providing educational services to students with complex health care needs. These policies address children with special health care needs in general and communicable diseases specifically.

Children with Special Health Care Needs

The Council for Exceptional Children's Task Force on Medically Fragile Students (1988) has developed specific recommendations focused on nine basic issues:

1. Determining eligibility for special education services.
2. Providing related and noneducational services.
3. Assuring equal access to appropriate educational settings in the least restrictive environment.
4. Promoting a safe learning environment for all students and professionals.
5. Assuring that health care services are delivered by appropriately trained personnel.
6. Establishing support systems for staff, students, and families.
7. Including appropriate information about students' specialized health care needs in preservice, inservice, and continuing education programs.
8. Providing appropriate and safe transportation.
9. Promoting research that assesses current and future service delivery models.

For each of these points, suggestions are made as to how they can be addressed to assure that each student with specialized health care needs receives an appropriate education program.

Iowa became the first state in the country to adopt a series of policy recommendations for dealing with children with special health care needs in the schools (Task Force on Children with Special Health Care Needs, 1988). These recommendations address the following needs:

1. To resolve issues relative to fiscal responsibility.
2. To involve health care professionals in IEP planning.
3. For statements by the Department of Education regarding evaluation and assessment practices and transportation needs.
4. For position papers on placement decision procedures, and service delivery issues including reevaluation, timelines, and care management responsibilities.
5. For the development of technical assistance and training for school personnel involved in the delivery of specialized health care for students.
6. The securement of model protocols and instructional materials for use by school nurses and staff responsible for providing health care to students.

Children with Communicable Diseases

Of the 59% of the 50 states and the District of Columbia responding to a recent survey, 70% had policies or guidelines regarding communicable disease in the schools (Lehr & Peppey, 1988). Considerable differences, however, were observed regarding thoroughness of the guidelines or policies regarding placement, exclusion, care-providing procedures, confidentiality, and case management.

The American Academy of Pediatrics (1988) has developed policies regarding infection control of HIV (AIDS) in schools. Changes in the guidelines reflect changes in our knowledge base regarding the spread of this infectious dis-

ease. The 1986 guidelines suggested excluding from preschool settings children infected with AIDS, which has great care-providing demands. The 1988 guidelines reflect a modification of those recommendations; these cite the risk of transmission as being so remote that there is no reason for exclusion.

The Council for Exceptional Children (1989) has developed a policy statement on managing communicable and contagious diseases in the schools. The policy emphasizes the need for case-by-case decision making, education of students and staff, protection for staff, and collaboration across agencies in policy development. The CEC policy statement also emphasizes the dynamic data base, which requires frequent review and revision of any established policies. The full text is given at the end of this article.

PROGRAM PRACTICES

Although this area of educational service delivery is relatively new, a number of recommendations regarding programs practices have been developed by those currently working with this population of students. Some of these will be discussed in the following sections. Emphasis is placed on recommendations relating to program planning, the development of communication systems, the training of involved personnel, and family-centered care management.

Program Planning

All students with needs for special education programs must have individualized education programs (IEPs) under the law. The same is true for students with special education needs who have complex health care needs. For those students, however, careful attention must be paid to developing plans that include all of the following (Caldwell, Todaro & Gates, 1989):

- Methods for assuring communication between and among family, school personnel, and medical providers.
- Provisions for transition from hospital or home to school.
- Identification of resources for technical assistance.
- Health care and emergency plans.
- Provision of training and monitoring of education personnel.

An additional emphasis is that of including IEP objectives that specifically relate to students' health care needs. Objectives designed to increase students' tolerance of, participation in, or implementation of the procedures are critical. Examples of these are given at the end of this article.

The development of health care plans is also an important part of comprehensive planning. Health care plans should include information such as what is to be done, the purpose of the service, the frequency with which the procedures should be implemented, under what conditions the physician should be contacted, personnel who should be involved and the training they should receive, how the procedures should be implemented, and the equipment needed (Ferguson, 1988). Procedures to be followed in the case of an emergency must be included.

Increasing Communication

Students with complex health care needs usually receive services from a number of professionals, representing a number of disciplines, usually located at different geographical locations. For example, a student might attend school in his or her home community but be under the primary care of a pediatrician located in the nearest large city, 90 miles away. The student may be receiving physical therapy from the school district, and speech therapy from a private clinic in the home community. The students also may be receiving 6 hours of home health nursing services daily, by a nurse employed by a private home health care agency.

In this scenario, the student, in addition to being involved with care providers (natural or foster family or residential home staff), the teacher, physical therapist, and two paraprofessional aides in the school, is receiving direct services from three other professionals. With this many individuals involved, communication and coordination becomes a major concern. How can consistent approaches be developed? How can all be informed of critical information?

One person should be identified as the coordinator for information flow to and from the schools. Often this person is the parent or the school nurse or the teacher. Caldwell, Todaro, and Gates (1989) have pointed out that the parent is most often the person responsible for coordinating information between schools and medical professionals. Those authors also pointed out problems with this model when the parent's role as primary liaison is only assumed and not specifically established, which results in a lack of routine reporting and selective reporting and the parent making assumptions regarding what is important. The same problem may occur, of course, when the teacher's or nurse's role is not made explicit.

A second set of important factors leading to effective coordination relates to communication attitudes and specific skills; communication attitudes such as self-acceptance, acceptance of others, and empathy have a powerful impact on the ways in which information is exchanged (Holvoet & Helmstetter, 1989). Parents who feel that a professional is not accepting of them or their child are not likely to be open in their discussions with that individual. The consequence may be a significant barrier to the necessary exchange of information.

Specific communication skills related to listening, nonverbal communication and verbal responding are also essential to assure coordinated care (Holvoet & Helmstetter, 1989). Among the skills necessary in these areas are careful, attentive, active listening; careful interpretation of nonverbal messages; verbal responding such as paraphrasing, summarizing, and clarifying. Development and use of these skills results in increased accuracy of the information exchanged.

Whoever is responsible for communication coordination and those who participate in the communication process have the tremendous task of collecting and transmitting accurate information to assure coordinated, consistent care of children. Without this, quality care can not be realized.

Training

Personnel involved in providing educational and specialized health care services to students with complex health care needs must be properly prepared. This is essential in providing the best possible services to students and also in reducing the risks for liability. The Iowa State Department of Education (Task Force on Children with Special Health Care Needs, 1988) has recommended that preservice training programs for special education teachers include information and training related to:

- Certification in first aid and CPR.
- Physical care, general health and nutrition information, infection control, skin care, elimination and oral hygiene, common childhood diseases.
- Community resources and how to access them.
- The team approach to service provision, confidentiality, and dealing with sensitive information.
- Effective IEP writing for children with special health care needs. (p. 7).

The Iowa Department of Education also recognized the need for ongoing training for teachers currently in the field and made recommendations for periodic inservice training on topics similar to those listed.

Additional emphasis must be placed on training staff in the hygienic care of all students to prevent spread of infection and contagious diseases. Proper handwashing has been identified as the single most important procedure for preventing the spread of infections (Silkworth, 1988). Other essential procedures to learn include the cleaning of diapering surfaces, instructional materials, and eating/feeding equipment.

The need for training regarding HIV infection is critical to assure that school professionals are informed about transmission modes. Knowledge that transmission does not occur through casual contact, or through contact with saliva or feces and urine, will contribute to the acceptance of students who test positive for HIV. This knowledge also will result in school personnel using Universal Precautions in caring for all students in the school setting. Recommendations by the American Academy of Pediatrics (1988) regarding care for students with HIV infection in the schools are:

1. HIV-infected children who are old enough to attend school can be admitted freely to all activities, to the extent that their own health permits. The child's physician should have access to consultative expertise to assist in decision making.

2. As all infected children will not necessarily be known to school officials in high-prevalence areas, and because blood is a potential source of contagion, policies and procedures should be developed in advance to handle instances of bleeding. Such policies and procedures should be based upon the understanding that even within an area of high prevalence, the risk of HIV-infection resulting from a single cutaneous exposure to blood from a school-aged child or adolescent with unknown serologic status is minute. Considering such minimal risk, the only mandatory precautionary action should be washing exposed skin with soap and water. Lacerations and other bleeding lesions should be managed in a manner which minimizes direct contact of the caregiver with blood. Schools in high-prevalence areas should provide access to gloves so that individuals who would wish to further reduce a minute risk may opt for their use. Under no circumstance should the urgent care of a bleeding child be delayed because gloves are not immediately available.

Family-Centered Care

Former Surgeon General C. Everett Koop has been a significant leader in calling for community-based (as contrasted with hospital-based) systems of services for students with special health care needs and their families (Gittler, 1988). Strong in his message is the importance of the family as central in each child's life: "The family is the constant whereas the public and private agencies, organizations, institutions and individuals that provided health and other needed services for the child are transitory" (p. 5). The campaign calls for development of supports to assist families in their natural role as the primary providers for their children. It calls for the development of systems in which partnerships are formed between professionals and families in all aspects of planning and service provision (Gittler, 1988).

Throughout the country, many projects are emerging to develop the necessary supports for family-centered, community-based care. Programs are incorporating the following elements (Shelton, Jeppson, & Johnson, 1987, p. 1):

- Recognition that the family is the constant in the child's life while the service systems and personnel within those systems fluctuate.
- Facilitation of parent/professional collaboration at levels of health care.
- Sharing of unbiased and complete information with parents about their child's care on an ongoing basis in an appropriate and supportive manner.
- Implementation of appropriate policies and programs that are comprehensive and provide emotional and financial support to meet the needs of families.
- Recognition of family strengths and individuality and respect for different methods of coping.
- Understanding of and incorporating the developmental needs of infants, children, and adolescents and their families into health care delivery systems.
- Encouragement and facilitation of parent-to-parent support.
- Assurance that the design of health care delivery system is flexible, accessible, and responsive to family needs.

Only through this orientation of the child as part of a family can educators working with families and other professionals from a variety of fields develop comprehensive, effective programs of education and care for children with special health care needs.

SUMMARY

Providing educational programs in least restrictive environments to students with complex health care needs is a new challenge to public schools. Many questions about the best ways to meet these students' educational and health care needs are still unanswered. Although attention to this group of students is increasing, much additional work is necessary. Solutions to these questions and issues are not simple and cannot be solved by the schools alone. Collaborative efforts among educational and medical fields and with families are essential.

Dissemination of information and preservice and inservice training of personnel are necessary to quality programs that combine education and care. It is also necessary to prevent discrimination against students and spread of communicable diseases.

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The Council for Exceptional Children's Policy Statement on *Managing Communicable and Contagious Diseases*

Controlling the spread of communicable and contagious diseases within the schools has always been a problem faced by educators, the medical profession, and the public. Effective policies and procedures for managing such diseases in the schools have historically been developed by health agencies and implemented by the schools. These policies and procedures were primarily designed to manage acute, temporary conditions rather than chronic conditions which require continuous monitoring and remove children from interaction with other children while the condition is contagious or communicable.

The increased prevalence of chronic communicable diseases such as hepatitis B, cytomegalovirus, herpes simplex virus, and acquired immune deficiency syndrome have raised public and professional concern, necessitating the reassessment of existing school policies and procedures. The Council believes that having a communicable/contagious disease does not in itself result in a need for special education. Further, the Council believes that in developing appropriate policies for managing communicable diseases, schools and public health agencies should assure that any such policies and procedures:

a. Do not exclude the affected child from the receipt of an appropriate education even when circumstances require the temporary removal of the child from contact with other children.
b. Provide that determination of a nontemporary alteration of a child's educational placement should be done on an individual basis, utilizing an interdisciplinary/interagency approach including the child's physician, public health personnel, the child's parents, and appropriate educational personnel.
c. Provide that decision involving exceptional children's nontemporary alterations of educational placements or services constitute a change in the child's Individualized Education Program and should thus follow the procedures and protections required.
d. Recognize that children vary in the degree and manner in which they come into contact with other children and school staff.
e. Provide education staff with the necessary information, training, and hygienic resources to provide for a safe environment for students and educational staff.
f. Provide students with appropriate education about communicable diseases and hygienic measures to prevent the spread of such diseases.
g. Provide, where appropriate, carrier children with education about the additional control measures that they can practice to prevent the transmission of the disease.
h. Enable educational personnel who are medically at high risk in regard to certain diseases to work in environments which minimize such risk.
i. Provide educational personnel with adequate protections for such personnel and their families if they are exposed to such diseases through their employment.

The Council believes that special education personnel preparation programs should:

a. Educate students about communicable and contagious diseases and appropriate methods for their management.
b. Counsel students as to how to determine their level of medical risk in relation to certain diseases and the implications of such risk to career choice.

The Council believes that the manner in which policies for managing communicable and contagious diseases are developed and disseminated is critically important to their effective implementation. Therefore, the following must be considered integral to any such process:

a. That they be developed through the collaborative efforts of health and education agencies at the state, provincial, and local levels, reflecting state, provincial, and local educational, health, and legal requirements.
b. That provision is made for frequent review and revision to reflect the ever-increasing knowledge being produced through research, case data reports, and experience.
c. That policies developed be based on reliable identified sources of information and principles endorsed by the medical and educational professions.
d. That such policies be written in content and format to be understandable to a variety of consumers including students, professionals, and the public.
e. That policy development and dissemination be a continual process and disassociated from pressure associated with precipitating events.

Source: Council for Exceptional Children, 1989, Policies Manual (Reston, VA: Council for Exceptional Children). Reprinted by permission.

Catheterization: Individual Education Plan (IEP) Recommendations

Level 1 - Total Dependence

Goal: (Self-Help) Maintain healthy urinary status by tolerating catheterization in a cooperative manner.

Objectives:

- The student's family will provide, on a daily basis, the equipment necessary for catheterization, 100% of time.
- The student will remain still in a lying position while the assistant performs catheterization in school at 8:00 a.m. and 12:00 noon, 100% of the time.
- The student will assist in assuming the correct position for catheterization when the assistant indicates it is time for the procedure, 90% of the time.

Level 2 - Direction of Care

Goal: (Self-Help) Maintain healthy urinary status and obtain maximum level of independence by learning how to direct care.

Objectives:

- The student's family will provide, on a daily basis, the equipment necessary for catheterization, 100% of time.
- The student will identify equipment needed for catheterization 4 out of 5 trials.
- The student will be able to verbalize "What comes next?" 4 out of 5 trials.
- The student will be able to independently (verbally) direct the step-by-step prescribed procedure to include the collection of materials, cleaning, catheterization, and then clean-up, 4 out of 5 trials.
- The student will be able to state warning signs and symptoms of problems related to catheterization and answer related, "What if?" questions, 4 out of 5 trials.

Level 3 - Independent Completion of Catheterization

Goal: (Self-Help) Maintain healthy urinary status through the independent completion of catheterization.

Objectives:

- The student's family will provide, on a daily basis, the equipment necessary for catheterization, 100% of time.
- The student will identify equipment needed for catheterization 4 out of 5 trials.
- The student will be able to answer questions about the procedure (i.e., "What comes next?") 4 out of 5 trials.
- The student will be able to independently (verbally) direct the step-by-step prescribed procedure for the collection of materials, cleaning, catheterization, and then clean-up, 4 out of 5 trials.
- The student will be able to independently gather equipment for the procedure, 4 out of 5 trials.
- The student will be able to demonstrate on a doll the step-by-step procedure for cleaning hands and genital area, 4 out of 5 trials. Note: This may be accomplished through the purchase of an inexpensive doll with a hole cut in the genital area.
- The student will be able to answer question, "Why are you cleaning your hands? . . . your genital area?", 4 out of 5 trials.
- The student will be able to demonstrate placement of catheter in the doll, 4 out of 5 trials.
- The student will be able to set up for self-catheterization and clean self following the prescribed step-by-step procedure, 4 out of 5 trials.

Male

- The student will be able to hold his penis in the correct position, clean himself and identify opening, insert the catheter, and follow the prescribed step-by-step procedure, 4 out of 5 trials.

Female

- The student will be able to open her labia, clean herself, and identify the urethra, insert the catheter, and follow the prescribed step-by-step procedure, 4 out of 5 trials.
- The student will be able to independently complete self-catheterization according to the prescribed step-by-step procedure, 10 out of 10 trials.
- The student will be able to state warning signs and symptoms of problems related to catheterization and answer related "What if?" questions, 4 out of 5 trials.
- The student will be able to independently complete self-catheterization according to the prescribed step-by-step procedure during monthly observation.

Source: T. Caldwell, 1988, *Children with Special Health Care Needs in School* (presentation at Conference Blue Print for Change. Council for Exceptional Children, Orlando, Florida). Reprinted by permission.

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A manual to provide teachers with relevant information regarding health-related procedures their students receive.

VIDEO TRAINING TAPES*

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Clean Intermittent Catheterization. Includes information regarding benefits of, and procedures for performing, CIC, as well as how to instruct others. 25 mins.

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Infection Control in Child Care Settings. Addresses necessary concerns regarding prevention of spread of contagious diseases in group care settings and provides instruction on effective control techniques. 30 mins.

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SCHOOL HEALTH RECORDS: NURSING PRACTICE AND THE LAW

by **Nadine Schwab, Mary Gelfman**

At the end of this article, the school nurse will be able to:

1. Identify documentation requirements of the *Standards of School Nursing Practice* (Task Force on Standards of School Nursing Practice, 1983)
2. Recognize the diversity of federal and state laws that affect record-keeping in public school districts
3. Discuss the professional-legal dilemmas of school nurses when documenting sensitive health information
4. Describe methods of documentation and record-keeping that maximize the quality of health services delivered to students, protect the student's and/or family's right to confidentiality, and minimize the nurse's and school district's liability

Introduction

Changes in school nursing practice and the nature of school health services have increased the school nurse's need to obtain and record confidential health information and to document care provided to students (Wold, 1981). As a result, school nurses are increasingly faced with professional-legal dilemmas related to health data collection, record-keeping, storage of confidential health information, protection of a student's and/or family's right to confidentiality, and the release of school health records, or any portion of them, to a parent/guardian or eligible student (Cohn, 1984). These professional-legal dilemmas generally occur for one of two reasons: first, a conflict exists between the ethics and standards of care which govern the professional practice of nursing (Schwab, 1988) and educational law or school policies; or second, a conflict exists between educational and health law. Application of the various laws and policies that pertain to the documentation of confidential health information in the school health office can present substantial

difficulty for today's school nurse, who provides a wide variety of sophisticated, individualized primary health care services to students (Gelfman and Schwab, 1991).

Documentation Standards in School Nursing

The National Standards of School Nursing Practice (Task Force on Standards of School Nursing Practice, 1983) require both adherence to the nursing process (assessment, diagnosis, planning, intervention and evaluation) and systematic and continuous documentation of care, including individualized school health plans with specific goals and interventions for students with health care needs in school. Such documentation includes:

- relevant historical data (subjective information);
- objective assessment data, including observation, developmental appraisal, and physical findings;
- nursing diagnoses based on the subjective and objective data;
- a management plan based on the nursing diagnoses; and
- on-going reassessment and revision of the plan as appropriate.

Each encounter with the student and each aspect of the nursing process must be adequately documented in order to promote consistent and continual care, regular evaluation of the nursing management plan, and subsequent revisions in care (Schwab, 1988; Wold, 1981). In addition, the Standards of School Nursing Practice require that the school nurse develop a data management system to facilitate (1) planning, implementation, and evaluation of the school health program and (2) monitoring of the health of school populations. These criteria are consistent with other general and specialty nursing standards regarding documentation of client care.

In malpractice cases against nurses, the courts refer to such standards in order to establish whether the nurse met the required standard of care. Almost without exception, the courts have held that "if it wasn't documented, it wasn't done." In a recent court case in Minnesota concerning the death of an asthmatic student (*Schuessler v Independent School District No. 200*, 1989), a school nurse was found liable for failing to sufficiently assess the student's condition and provide appropriate interventions. The school nurse tried to establish that she had appropriately assessed the student's condition, but there was no documentation of her care to support this assertion and in light of other testimony, the court ruled otherwise.

While the Standards of School Nursing Practice and related standards in the nursing profession are clear regarding documentation responsibilities of the school nurse, application of these standards in the school setting is extremely complex. In order to appreciate this complexity, it is necessary to understand the federal and state laws that apply to school health records, as well as the requirements of one's local school district policies. The primary federal legislation affecting record-keeping in public schools is the Family Educational Rights and Privacy Act, also called the Buckley Amendment, or "FERPA." Whether or not the school nurse is directly employed by the school district, student health records are considered school records, subject to the provisions of FERPA.

FERPA Requirements

The federal law requiring confidentiality of student records in public schools, the Family Educational Rights and Privacy Act of 1974 (FERPA, 20 U.S.C. §1232g, 1974), was adopted in response to reported abuses of confidentiality, denial of parental access, problems concerning correction or deletion of inaccurate or outdated material in student files, and lack of consistency in record-keeping among school districts across the country. Regulations for full implementation of FERPA were published in the *Federal Register*, June 17, 1976; these regulations were re-codified from 45 CFR Part 99 to 34 CFR Part 99 May 9, 1980 (45 Fed. Reg. 39892ff, 1980), and revisions of these regulations were published in the *Federal Register*, April 11, 1988 (53 Fed. Reg. 1194ff, 1988). Additional federal requirements concerning the confidentiality of school records and student privacy issues appear in the 1978 General Education Provisions Act (GEPA) (20 U.S.C. §1232h, 1978) and the Education of All Handicapped Act (EHA) of 1975 (20 U.S.C. §1415(b)(1)(A), 1975).

The fundamental requirement of FERPA is that every school district receiving federal funds for any program must publish a records policy and annually notify parents and students over 18 years of age about it. These policies must meet certain standards as defined by the Act:

1. Records concerning individual students, containing "personally identifiable information," must be kept confidential and not released by the school without written parental consent or consent from students over age 18.
2. Parents and guardians of students under 18, and students over 18, have the right to inspect all school records concerning that student.
3. The school district record-keeping system must be described in sufficient detail so that parents will be able to locate each place where their student's records may be found.
4. School district staff members with access to student records must be identified by title.
5. Each student's file must include a record of access, on which all school staff members must sign whenever they consult that student's file.
6. Parents have the right to appeal anything in a student's file which they consider inaccurate, misleading or in violation of the student's rights of privacy or other rights; and, if the school district is unwilling to delete such challenged material, the parent may request a hearing and/or provide a written statement to be attached to the challenged material.
7. The school district must define what constitutes "directory information," under what circumstances that information may be released without parental consent, and how a parent may have "directory information" concerning his or her child protected from release.

However, treatment records "...made or maintained by a physician, psychologist, or other recognized professional or paraprofessional acting in his or her professional capacity..." and used in the treatment of an "eligible student," that is, a student over the age of 18 years of age or any student in an institution of postsecondary education, are excluded from the definition of "education records" in FERPA and are not automatically accessible to the student (34 C.F.R. §99.3 (b)(4)).

An exception to the parental consent requirement (see #1 above) is made for disclosures to state or local officials, as required by state statute adopted prior to the enactment of FERPA. An exception to parental access (see #2 above) is provided for "personal notes" which are defined as "not education records" (20 U.S.C. §1232g(a) (4) (B) (i) and 34 C.F.R. §99.3, "Education Records," (b)(1)) and therefore exempt. Personal notes refer to notes generated by one school staff member for his or her own use. By definition, such personal notes are also not accessible to any other school staff member except a substitute for the original note-maker. According to FERPA, therefore, the school nurse may keep "personal notes" about services provided to an individual student so long as she does not share those notes, or the contents of the notes, with anyone else except a nurse who substitutes for her. "Substitute" may apply to the nurse's supervisor if the supervisor is a nurse who may be responsible for providing services when the school nurse is absent.

Requirements of State Laws

State requirements addressing school records in the same context as FERPA are rare, probably because FERPA addresses school districts directly. There are, however, other statutory protections and specific privileged relationships that an individual state may define. These state laws and regulations must also be recognized by school district personnel responsible for maintaining school health records. For example, Connecticut statutory provisions, Section 10-15b, C.G.S., subsection (a), provides that parents have access to "...all educational, medical, or similar records maintained in such student's cumulative record..." upon written request and within "reasonable" time; and Section 10-154a, C.G.S., protects the communications about drug and alcohol abuse problems between students and teachers, school nurses, or school administrators and excludes them from release. Section 10-15b(b), C.G.S., also provides procedural safeguards when a student's school records are subpoenaed by a court, extending the FERPA protections by requiring the sealing of student records within court records.

Additional legal protections include state laws that provide for a minor's right to seek treatment for certain conditions, such as tuberculosis, pregnancy, drug and alcohol problems, and/or sexually transmitted diseases. Other state laws may protect communications between a client and psychiatrist, psychologist, sexual assault counselor, judge, clergyman, or other service provider, depending on the state. Finally, some states have strict confidentiality requirements on all documentation of an individual's HIV status (Connecticut P.A. 89-246, 1989). Many of these state enactments appear to be in conflict with FERPA. Since the legal outcome of such conflicts will vary, a school nurse should consult her supervisor prior to taking any action to release or refuse to release school health records when state law appears to conflict with FERPA and/or local school district's records policy. Whether these various legal protections are applicable to nursing services in a public school setting is uncertain, and whether state statutes protecting a minor's right to seek specific health services extend to the services of a school nurse who counsels and refers the student for medical care is not yet legally established. Clearly, however, school nurses must know and understand the various laws in their own states that pertain to the confidentiality of communications with students, as well as the maintenance and release of school health records. When the law is not definitive as indicated above, school nurses must practice according to nursing professional standards, which do clearly require the nurse to protect a client's right to privacy around information of a confidential nature (American Nurses' Association, 1976).

Professional-Legal Dilemmas

The professional-legal dilemmas that school nurses currently face regarding documentation and record-keeping practices generally fall into one of the following categories: traditional school nursing documentation practices; maintenance of confidentiality; child abuse; and nursing records for students with chronic health impairments.

Traditional School Nursing Documentation Practices. In general, record-keeping systems related to school health services have included three categories of records. These are (1) the school health record or health card, as required by law, usually including immunization data, records of vision, hearing, and other health screenings, and mandated physical examinations; (2) records of student visits to the health office; and (3) more detailed medical and hospital records provided to the nurse for health services planning, or to the school to assist in educational planning. Traditional school health records or cards and other methods of documenting student care, however, are frequently not consistent with the requirements of the Standards of School Nursing Practice, or even with FERPA.

The traditional four-sided school health record or card provides space for documenting routine health data that schools need in order to (1) ensure compliance with state mandates; (2) provide appropriate care in the event of an emergency; and (3) document screenings and physician orders for alterations in the school program for health reasons. It does not, however, provide space for ongoing nursing process notes beyond infrequent, episodic visits to the nurse for acute illness or injury that occurs in school. In addition to the limitation of space, use of the school health record is constricted since, in

many instances, nursing process notes regarding students' confidential health problems or concerns (Cohn, 1984) and additional medical data provided by physicians and health care facilities are not relevant to the student's education and are, therefore, not appropriate as part of the educational record. The specific issue of confidentiality is addressed in more depth in the next section.

Another type of record traditionally used by many school nurses for documenting student visits to the health room is the "daily log." While this system may have developed as a solution to the health record's limitations of space and confidentiality as cited above, there are significant problems with the log method of documentation. Because daily logs are organized by date rather than by student, notes recorded on such a log are not readily retrievable in a format consistent with the nursing process. It is impossible for the school nurse to retrieve all past nursing process notes pertaining to an individual student without going through the entire log, or even several log books for the same or previous years, whenever that student visits the health office. Although the daily log does keep potentially sensitive nursing notes off the formal school health record and provides an easy method for statistical analysis of school health office visits, it is not conducive to safe nursing practice. Consistent and continual care, regular evaluation of the nursing management plan, and subsequent revisions in care are not feasible without immediate access to previous nursing process notes. Indeed, use of a daily log as the sole method of documentation of individual student care is contrary to professional standards for nursing documentation. For example, without individualized student records of episodic visits to the health room, it may take the nurse much longer to recognize a pattern indicative of underlying physical or mental health problems in apparently healthy students. Additionally, since FERPA requires that parents have access to documents about their children, the chronologic log is also a violation of FERPA. It does not meet the criteria for exclusion from FERPA either as a "treatment record" of a student over the age of 18 years or as the nurse's "personal notes."

The third type of health records, those sent to schools for school health services and educational planning, are equally problematic. In general, these health records are stored either with the student's school health record/card or with special education records. In either location, such health care records may not be sufficiently protected by school district policy. As a result, they may be accessible to school personnel who do not need or have a right to the information contained therein, or do not have sufficient expertise to interpret the information correctly. Once in school records, these third-party records are considered "educational records" and are, therefore, accessible to parents (Janda, 1978).

Confidentiality and Minor's Rights. Since federal and state laws, and school district records policies were developed primarily to address academic records, not health records, there are often insufficient protections in schools regarding students' health records, storage of such records, and access to them by other school personnel. As a result, confidentiality of student health information is frequently a predominant issue for the school nurse. When the nurse opts not to record nursing process notes on the student's record because of confidentiality concerns, the issue of where to record such notes is equally problematic. While documentation of care is critical both to the provision of safe and continuous services and to the nurse's future ability to demonstrate that safe and appropriate care was rendered, an appropriate place in the school setting to document such information is not always available or recognized in school records policy.

Many students seek out members of the school staff, especially the school nurse, about private health concerns. There are a variety of common and statutory (state) law protections for student communications concerning drug and alcohol abuse, pregnancy, abortion, venereal diseases, and mental health issues. Some states have parental notice requirements concerning a minor's reproductive questions. A student's communications with each of a variety of professionals, for example, the guidance counselor, school social worker, school nurse or nurse practitioner, or teacher, may have some confidentiality rights, depending on the state. Overriding all technical concerns, however, must be the safety of the student and the school community. Until recently, the issue of possible conflict between these state confidentiality protections and FERPA-guaranteed parental access appeared to be merely an issue of state/federal law conflict. However, the U.S. Department of Education and the (federal) Alcohol, Drug Abuse and Mental Health Administration issued a joint opinion on September 26, 1990, addressing conflicts between federal regulations in FERPA and the federal confidentiality regulations (42 C.F.R. Part 2) as they apply to Student Assistance Program (SAP) records (Sullivan and Rooker, 1990). This joint opinion suggests that local school districts either (1) require that students consent to parental access to their records as a condition of receiving SAP services or (2) obtain a Court order to permit disclosure of Student Assistance Program information to a parent who seeks it under FERPA. Additional comments include reference to the personal notes exception (team notes cannot be construed as personal notes) and the distinction between written records and nonrecorded data. Given the compelling policy implications on both sides of this conflict, it is reasonable to expect continuing debate about the balance between parental access and minor student confidentiality.

The rights of minors to health services, in emergencies (conditions that require prompt treatment), or without consultation with or consent from parents, has evolved in both common and statutory law (Holder, 1987). Physicians and nurses, among other health care providers, rely on "right to treatment" law and "Good Samaritan" protections. In some states, minor treatment statutes provide a specific age (usually 16, but as young as 14 years) at which a minor may consent to (and thus

maintain confidentiality about) some general medical treatment and health care services as if he or she were an adult (e.g., Miss. Code Ann §41-413(h); N.H. Rev. Stat. Ann. §318-B; Idaho Code §39-4302; Nev. Rev. Stat. §129.030(2); as cited in English and Tereszkiewicz, 1988). FERPA is silent on the rights of "mature" and/or "emancipated" minors and related health care confidentiality issues. FERPA does provide, however, that when a student becomes 18 years of age, the student (now an "eligible student") may assert rights to his or her school records. Parents who can establish that an adult student is reported as a dependent on the parent's federal income tax return may continue to assert parental rights of access as well.

Since FERPA requires parental access upon request to all school records, the school nurse is in a serious conflict when approached by a minor student requesting confidential advice or referral concerning health problems, especially when a minor's right to consent to the referred service is established by state law or is constitutionally protected. For example, if the nurse documents on the school health record her communications with a pregnant student, the parents have an absolute right to that record despite the student's desire to seek health care on her own. In addition, other nonmedical school personnel may have access to the record and, therefore, to the nursing process notes of such sensitive, noneducational health information. If the school nurse does not document this information, however, the nurse is not practicing according to the Standards of Practice for School Nursing. Lack of documentation puts the student at increased risk for delayed or inappropriate intervention by the nurse or nurse substitute. In the same example, the student may choose to have an abortion and then later suffer a complication while at school. Because the school nurse cannot access prior nursing process notes relevant to the assessment and management of the student's condition, the nurse is at greater risk for making an error in judgment or for delaying emergency intervention. As a result, the nurse and the local school district are also at increased risk of liability.

Child Abuse. Documentation of reports of suspected child abuse and neglect provides another professional-legal dilemma for nurses working in the school setting. In every state, there are laws requiring that people who have professional responsibility for children report suspected child abuse to the designated child care agency. The school nurse plays pivotal roles on the school team, as potential observer of suspicious injuries or inconsistencies in histories provided by students and as recorder of clinical observations necessary for such reports.

The nursing dilemma involves both documentation of clinical observations made by the nurse in support of a report and issues of storage, access to, and maintenance of the copy of the report made to the child welfare agency. Often school district policy will prohibit the inclusion of such information on school records, including the school health record, in order to protect the privacy of the child and family. Understandably there is concern that the report is only of suspicion, not of established fact, and that some such reports will be in error. There may also be concern that an angry or potentially violent parent/step-parent will request the documented report information from the record. The first responsibility of the nurse, however, is to safeguard the student. If the nurse does not document observed signs and symptoms of abuse or neglect on the health record, the student may be at increased risk for misdiagnosis of further injury observed by a different nurse in another school building or district in the future. Additionally, the school health record containing the nursing assessment in a case of suspected abuse/neglect is the legal record of health services provided in the district and, when subpoenaed by the courts, should assist the child protection agency to demonstrate the need for intervention on behalf of the child. By the time a case is investigated and gets to court, the nurse's written documentation of clinical observations may be the only objective evidence recorded by a health professional at the time of the referral and may, therefore, be essential evidence in court proceedings to intervene for the child.

Children with Chronic Health Problems. There have always been children with health problems in public school, but the numbers of such children and the severity of their health impairments have increased dramatically. The 1973 Rehabilitation Act, §504 (29 U.S.C. §794), guarantees the educational rights of any child in public school who is disabled, has a history of disability, or may be regarded as disabled. Coupling these rights with the principle of Least Restrictive Environment, (34 C.F.R. 104.34(a)) there are more children attending public school today who have complex, even life-threatening, health problems. The school nurse faces the dilemma of maintaining appropriate records in order to provide health care support in school while also protecting the child and family from release of personal medical information. The AIDS crisis has made this issue particularly sensitive, since unauthorized release of information concerning an individual or family member's HIV status can have serious social and economic consequences.

Similarly, nurses recognize that information about any chronic health condition, specific diagnosis and/or medical treatment should be considered confidential, just as it would be in a hospital or other medical setting. While the school nurse requires information about the health status of a child in order to plan and provide appropriate school health services, many of the details, including diagnosis, should not be shared with or made accessible to other school personnel without good cause and specific permission from the parent/guardian. An additional issue in documenting care for students with on-going health service needs is where to document such records of nursing care. The standard school health record/card, once again, provides insufficient space for continuous nursing process notes, changing health care plans, treatment logs, and

related documentation. Furthermore, protections for such health information and specific policies regarding confidential health or nursing records are usually not addressed in local school district policies.

Recommendations

In keeping with the current laws addressing school health records, related legal issues, and the standards of practice for nursing documentation, several recommendations will be made here. These are intended to improve the local school district's policies and procedures regarding school health records and protection for confidential health information of students and families. At the same time, they should help to minimize the professional-legal dilemmas related to nursing documentation in schools.

The recommendations are divided into the following categories: (1) health record systems: categories, maintenance, and storage; (2) access and confidentiality; (3) child abuse/neglect documentation. It is essential to recognize that these recommendations are general, and will require adaptations in individual school districts, based on differences in relevant health and educational state laws, health care needs and ages of the student population, and differences in staffing.

Health Record Systems: Categories, Maintenance and Storage. Since records kept by the school health office concerning students in a school are subject to FERPA, a local school district records policy must identify what records are maintained and where they can be located. The recordkeeping system should include three categories of records:

1. The school health record as required by law, usually including immunization data, records of vision, hearing, scoliosis, and other screenings, and mandated physical examinations;
2. Nursing records of student assessments, care plans, interventions and evaluations (whether provided in the health office or in other school locations); and
3. Medical and hospital records provided to the school to assist in health services and educational planning.

The first category, the school health record/card, should be designed to incorporate the information required not only for the safety of students but also to document the school's compliance with school public health requirements. The school health record should incorporate only the information necessary for the child's attendance in school. It should include major health needs or physical restrictions in school, major accidents or injuries that occur in school, and a summary of school health planning and services relative to the student's education that are provided in school. Some states mandate the exact contents and/or form for this student school health record. When a student moves to another school, this is the record that is sent to the new school.

While the second category of records is not always recognized in district records policies or state law, it provides the nurse with a place to record nursing process notes and treatment logs for students with chronic health problems, to document sensitive health information shared by the student or family, and to record episodic visits to the health office. Depending on the needs of the student population for health services, age of students, and extent and type of nursing services provided in the district, such a system might consist of:

- a card file system, in which each student has a separate card;
- a notebook or record system, in which each student record occupies a separate section of the notebook or an entirely separate notebook or record; or
- a computer program with individual student records adapted for nursing assessments, care plans, process notes, and treatment logs.

These records (or copies thereof) should not be sent to another school district or agency without the written permission of the parent, but may be copied and/or summarized for the parent to take and share as appropriate. For a medically complex student, a summary of the health services provided each year should be attached to or included in the student's school health record/card and in the student's special education record (if applicable). The Multnomah Education Service District in Oregon (Hootman, 1990) has developed an exemplary record-keeping system, which is incorporated in a school nursing procedure manual.

The third category of records includes records that have been released from physicians and hospital settings in which they were highly protected. Of primary concern is that the school inform outside health care providers that documents sent to the school will be accessible to the child's parents. While some state medical records laws allow a physician to deny access to the patient or to a minor patient's parent, this scheme conflicts with the requirement of parental access under FERPA. School districts should request that health care providers send a *summary* of health information relevant to the student's education and health

(continued on next page)

care needs in school rather than a copy of the entire record. Also of primary concern is the necessity for schools to provide additional confidential protections for such records within the school community. Recommendations regarding access to such records and the confidentiality issues regarding them follow.

Access and Confidentiality. The school nurse and other staff members assigned to the school health office are responsible for ensuring that the confidentiality of school health records is maintained. The school nurse must inform herself about the requirements of the local school district's records policy and ensure that their requirements are met. Furthermore, the school nurse may need to recommend changes and/or additions to that policy, specifically addressing confidentiality of student health information and nursing documentation requirements for the provision of safe health care services for students.

All school health records (category 1) should be classified to provide maximum protection. Access to the school health record/card should be limited to school health office personnel and, in the absence of such personnel, to the appropriate school administrator. When school health records are accessed by any school administrator, a health care professional should be available to interpret the health data (Gelfman and Schwab, 1991).

Access to nursing records (category 2) and third-party records sent to the school nurse for the purpose of health assessment and care planning (category 3) should be limited, as in the Multnomah Education Service District, to the staff nurses, nurse supervisor, parent, student, and student nurses and their instructors working in a contractual relationship with the school district. In Multnomah's system, parents have access to the record except where the student has a specific right to privacy. School nurses establishing similar record-keeping procedures should seek legal advice as to specific state laws and possible conflict with FERPA (Gelfman and Schwab, 1991).

Where such a system of separate nursing records is not yet feasible, or until conflicts with FERPA are resolved, another solution to the problem of protecting a minor student's right to confidentiality is the use of the "personal notes" exception in FERPA. A system of individual cards or files can be used to document on-going nursing process notes. As indicated above, however, the contents of such personal notes may not be shared with anyone except the note-maker's substitute. Once shared, the notes must become part of the school record, and can be accessed by parents. Additionally, some may feel that such notes are actually made by two people (the student who gives the history and the nurse who records and interprets the history and related objective data). Under this interpretation, such nursing process notes may not actually meet the criteria of "personal notes" as set forth in FERPA.

Third-party records sent to the school for educational planning (category 3) should also be accorded as much protection as the school can provide, subject to FERPA. Records released from hospitals are frequently marked "confidential" with a citation to confidentiality statutes protecting health records. As mentioned above, once such records become part of a student's school health file, FERPA parental access requirements must be honored.

After completing an assessment of a student's health status, the school nurse should develop, as appropriate, a health summary, an individualized health care plan, an emergency care plan and/or other necessary documentation. These should be accessible to school staff just as any student's Individualized Education Program (IEP), schedule, attendance records, etc. are accessible to them. After the school nurse prepares such plans or makes appropriate notes concerning an individual student's health needs on the school health record or communicates them to teachers, the medical or third-party records should be retained in an extra-confidential file with access limited to the nurse, parent, and student. In districts where school nurses are unavailable, this extra-confidential record may also need to be accessible to an appropriate school administrator on a need-to-know basis.

In keeping with FERPA requirements, the nurse's responsibility for student health records includes ensuring that an access log for every student's health record or file is maintained. Local district policy must list who has access to the student's health records (by category) and who must sign whenever a student's record is consulted. For example, the policy may state that the school nurse has routine access to student health records and need not sign the access sheet while other designated staff, if so allowed, must sign in on the access sheet whenever they open a student's health record. Such an access sheet must be in the regular school health record as well as the nursing and extra-confidential files for third-party records. The nurse must also ensure that parental consent is obtained before health information is released outside the school, for example, when the special education team is considering placing a medically involved student in another school and wants to share the student's health records with that school, or when the school is seeking additional evaluative data for medical or other consultants to assist in educational planning.

Child Abuse/Neglect Documentation. In documentation of instances of suspected abuse and neglect, it is essential to develop a record-keeping system that protects the safety of the child without undue compromise of the child's and family's privacy. Court decisions have held that the duty to report or to protect the child from potential harm supersedes confidentiality rights (Schwab, 1989). Policies should provide the following:

- Safety of the student is the foremost consideration in all decision-making regarding intervention and documentation.
- All matters concerning reports of suspected child abuse should be classified as highly protected.
- The school copy of the referral form for suspected abuse should be kept in an extra-confidential file developed for such purposes, with access limited to the school nurse

Continuing Education Test on School Health Records

Each of the ten questions has one correct answer.
Decide on your answer, and mark it on the special answer sheet on page 34.

1. School health office records about individual students must meet the requirements of
   A. state law standards.
   B. school district records policies.
   C. federal law — Family Educational Rights to Privacy Act (FERPA).
   D. all of the above

2. Consistent with federal law concerning public school records, a school nurse must allow a minor child's parent to inspect
   A. a record of their child's visits to the school health office.
   B. statistical record of student visits to the health office.
   C. vision and hearing screening results by class.
   D. all of the above

3. If a school nurse receives a record of the hospitalization of a student, according to FERPA the nurse must
   A. maintain the confidentiality status of the hospital record as required by state law.
   B. inform the child's teacher of the hospitalization.
   C. allow the child's parent to inspect the record if the parent makes a request.
   D. keep the record in a personal file and show it to no one.

4. Use of a daily log to record student visits to the health office is problematic because
   A. it is not consistent with the requirements of FERPA.
   B. it is not consistent with nursing standards of documentation.
   C. it increases the school district's risk of liability.
   D. all of the above

5. Parents may request that information be deleted from a student's record because it is
   A. critical of the child or family.
   B. inaccurate, misleading or in violation of the student's right of privacy or other rights.
   C. sensitive.
   D. all of the above

6. The Family Educational Rights to Privacy Act (FERPA) is a federal law that
   A. requires that each student record include a log of access by school staff members.
   B. makes school health records available to students over the age of 18 years.
   C. requires every school district that receives federal funds to have a student records policy.
   D. all of the above

7. If the school's designated records custodian refuses to delete information that a parent wants removed from his or her child's record, FERPA provides that the parent may
   A. file a law suit.
   B. attach a statement of his or her position to the challenged material.
   C. complain to the Board of Education.
   D. not do anything about it.

8. When federal law and state law conflict, the nurse is best protected if she or he
   A. follows professional nursing standards and obtains legal consultation.
   B. follows the federal law.
   C. follows the state law.
   D. follows the most recent law.

9. Details related to the disclosure of sexual abuse by a student are best documented
   A. on the child protection agency report form only.
   B. on the child protection agency report form and the school health record.
   C. on the child protection agency report form and in an extra-confidential file.
   D. on the school health record only.

10. Specific details regarding the health status of a student with a chronic disease, including the diagnosis, should be shared
    A. with all school personnel who work with the student.
    B. only with school personnel who have good cause to know.
    C. with school personnel who have good cause to know, but only after the parents have given permission.
    D. only with school personnel who have good cause to know, but only after the school principal has given permission.

Answer Sheet for CE Test on School Health Records Credit: 1½ contact hours

Check (✓) the correct answer.

1.	☐ A	☐ B	☐ C	☐ D	6.	☐ A	☐ B	☐ C	☐ D
2.	☐ A	☐ B	☐ C	☐ D	7.	☐ A	☐ B	☐ C	☐ D
3.	☐ A	☐ B	☐ C	☐ D	8.	☐ A	☐ B	☐ C	☐ D
4.	☐ A	☐ B	☐ C	☐ D	9.	☐ A	☐ B	☐ C	☐ D
5.	☐ A	☐ B	☐ C	☐ D	10.	☐ A	☐ B	☐ C	☐ D

Name _____ Telephone _____

Address _____

City _____ State, Zip _____

Social Security number _____

Licensure, state(s) in which issued _____

Copy or cut this answer sheet, and mail along with the appropriate fee: NASN Member $10, Non-Member $15 to: NASN Home Study Program, P.O. Box 1300, Scarborough, ME 04070-1300

and a specific school administrator (staff members making subsequent reports will need to determine whether there is a history of reports; this can be done through consultation with the nurse or designated administrator).

- The school nurse records objective historical or physical findings from any clinical assessment performed in support of a report of physical abuse or neglect on the student's school health record/card as well as on (or attached to) the report form.
- Because of the extreme sensitivity of historical data in instances of suspected sexual abuse, details of a nursing assessment should be documented in the extra-confidential file rather than on the school health record. Only notation that a report was made to the child protection agency should be entered on the child's school health record in order to alert a nurse in another district to the history of report(s) should the family move.

Not all professional-legal dilemmas that the nurse faces in regard to documentation and records in schools will be resolved, even with implementation of the above recommendations, because conflicts still exist between educational laws and health care laws regarding rights of minors and confidentiality of health information. A more in-depth analysis of these conflicts and additional recommendations related to changes in FERPA and state laws regarding health records in the school setting are contained in an article by Gelfman and Schwab (1991) in *Education Law Reporter*. Until such conflicts are resolved, the nurse should rely on the standards and ethics of the nursing profession and may need to seek expert professional-legal consultation for guidance in resolving difficult local issues.

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Additional Resources—

In 1991, the National Association of School Nurses will publish a manual on documentation to assist school nurses in understanding and applying the principles of sound nursing documentation in the school setting. The publication will provide samples of different types of forms utilized across the country.

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HANDWASHING AND USE OF GLOVES

Handwashing is the single most effective tool that we can use to protect ourselves, other staff and students from the transmission of infectious diseases. Although handwashing is a routine procedure, the use of proper technique enhances its effectiveness. Because of the vital role handwashing plays in the control of infectious diseases, the steps involved in handwashing and the rationale for these steps should be reviewed regularly with staff and students.

A. HANDWASHING

Purpose: To reduce the number of microorganisms on the hands

Equipment:
1. Liquid soap in dispenser (preferred to bar soap)
2. Paper towels
3. Hand lotion
4. Covered waste receptacle with disposable plastic liner

Procedure:
1. Remove all jewelry. Jewelry should not be worn when working with students who require repeated physical contact and care. Microorganisms can become lodged in the settings or stones of rings.

2. Wet hands with warm running water. Warm water, combined with soap, makes better suds than does cold water. Hot water removes protective oils and will dry the skin. Running water is necessary to carry away dirt and debris. The key element is the combination of soap, friction, time, and running water. (Warm water is not essential.)

3. Wash hands, using a circular motion and friction, for 15 to 30 seconds. Include the front and back surfaces of hands, between the fingers and knuckles, and around the nails and the entire wrist. Avoid harsh scrubbing to prevent skin breaks.

4. Rinse hands well under warm running water. Hold the hands under the water so that water drains from the wrist area to the fingertips.

5. Dry hands well with paper towels and turn off the faucet with a dry towel; discard the towels. Because of frequent handwashing, it is important to dry the hands gently and thoroughly to avoid chapping. Chapped skin breaks open, thus permitting germs to enter one's system.

6. Apply lotion as desired. Lotion helps to keep skin soft and reduces chapping.

Documentation: Recording of handwashing is not necessary. In special circumstances, for example if there has been an outbreak of illness in the classroom or school, it may be necessary to record handwashing by staff members.

B. USE OF GLOVES

The body fluids of all persons should be considered potentially infectious. To avoid direct skin contact with body fluids when assisting a student, use disposable gloves whenever possible. If the gloves are torn, leaking, or in any way defective, discard gloves, wash hands and use a new pair. Use gloves only once and for one student only; then dispose of them in the proper manner.

Purpose: To remove soiled gloves without touching contaminated surface with bare hands.

Procedure for glove removal:

1. With gloved right hand, pinch palm of glove on left hand and pull left glove down and off fingers. Form left glove into a ball and hold in fist of right hand while removing right glove as follows.

2. Insert two fingers of left ungloved hand under inside rim of right glove on palm side.

3. Push glove inside out and down onto fingers and over left glove without touching outside of glove.

4. Grasp gloves, which are now together and inside out, with left hand and remove from right hand.

5. Discard gloves in plastic bag with any used first aid materials. Seal bag before disposal.

6. WASH HANDS (See preceding procedure). Remember, wearing gloves is not a substitute for good hand-washing.

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APPENDIX G

GUIDELINES FOR HANDLING BODY FLUIDS IN SCHOOLS

Recent concern about how children with HIV should be educated has raised several questions regarding exposure of teachers and children to potentially infectious body fluids from children with communicable diseases in the school setting.

1. Does contact with body fluids present a risk of infection?
2. What should be done to avoid contact with potentially infected body fluids?
3. What should be done if direct contact with body fluids is made?
4. How should such fluids, when spilled, be removed from the environment?

The following guidelines are meant to provide simple and effective precautions against transmission of disease for all persons, including pregnant women, potentially exposed to the blood or body fluids of any student. No distinction is made between body fluids from students with a known disease and those from students without symptoms or with an undiagnosed disease.

Does Contact With Body Fluids Present a Risk?
The body fluids of all persons should be considered to contain potentially infectious agents (germs). The term **body fluids** includes: blood, semen, drainage from scrapes and cuts, feces, urine, vomitus, respiratory secretions (e.g., nasal discharge) and saliva. Contact with body fluids presents a risk of infection with a variety of germs. In general, however, the risk is very low and is dependent on a variety of factors including the type of fluid with which contact is made and the type of contact with it.

Table 1 on the following page provides examples of particular germs that may occur in body fluids of children and the respective transmission concerns. It must be emphasized that with the exception of blood, urine and semen, which are normally sterile, the body fluids with which one may come in contact usually contain many organisms, some of which may cause disease. Furthermore, many germs may be carried by individuals who have no symptoms of illness. These indivduals may be at various stages of infection: incubating disease, mildly infected without symptoms, or chronic carriers of certain infectious agents including the HIV and hepatitis viruses. In fact, transmission of communicable diseases is more likely to occur from contact with infected body fluids of unrecognnized carriers than from contact with fluids from recognized carriers because simple precautions are not always carried out.

Table 1
Transmission Concerns in the School Setting
Body Fluid Source of Infectious Agents

Body Fluid Source	Organism of Concern	Transmission
Blood -cuts/abrasions -nosebleeds -menses	Hepatitis B virus HIV (AIDS) virus Cytomegalovirus	Bloodstream inoculation through cuts and abrasions on hands
-contaminated needle	Hepatitis B virus HIV (AIDS) virus Cytomegalovirus	Direct bloodstream inoculation
-bites	Hepatitis B	Direct bloodstream inoculation
Feces -incontinence	Salmonella bacteria Shigella bacteria Rotavirus Hepatitis A virus Giardia	Oral inoculation from contaminated hands
Respiratory Secretions -saliva -nasal discharge	Mononucleosis virus Common cold virus Influenza virus	Oral inoculation from contaminated hands
Semen	Hepatitis B virus HIV (AIDS) virus Gonorrhea	Sexual contact (intercourse)
Urine -incontinence	Cytomegalovirus	Bloodstream and oral inoculation from contaminated hands
Vomitus	Gastrointestinal viruses (e.g., Norwalk virus, rotavirus)	Oral inoculation from contaminated hands

What Should Be Done To Avoid Contact With Body Fluids?

When possible, direct skin contact with body fluids should be avoided. Disposable gloves should be available and accessible to staff. Gloves are recommended when direct hand contact with body fluids is anticipated (e.g., treating bloody noses, handling clothes soiled by incontinence, cleaning small spills by hand). Gloves used for this purpose should be put in a plastic bag or lined trash can, secured, and disposed of daily.

What Should Be Done If Direct Skin Contact Occurs?

In many instances, unanticipated skin contact with body fluids may occur in situations where gloves may not be immediately available (e.g., when wiping a runny nose, applying pressure to a bleeding injury, helping a person in the bathroom). In these instances, hands and other affected skin areas of all exposed persons should be routinely washed with soap and water after direct contact has ceased. Clothing and other nondisposable items (e.g., towels used to wipe up body fluid) that are soaked through with body fluids should be rinsed and placed in plastic bags. If presoaking is required to remove stains (e.g., blood, feces), use gloves to rinse or soak the item in cold water prior to bagging. Clothing should be sent home for washing with appropriate directions to parents/teachers (see following page). Contaminated disposable items (e.g., tissues, paper towels, diapers) should be handled with disposable gloves.

How Should Spilled Body Fluids Be Removed From The Environment?

Most schools have standard procedures already in place for removing body fluids (e.g., vomitus). These procedures should be reviewed to determine whether appropriate cleaning and disinfection steps have been included. Many schools stock sanitary absorbent agents specifically intended for cleaning body fluid spills (e.g., ZGOOP, Parsen Mfg. Co., Philadelphia, PA). Disposable gloves should be worn when using these agents. The dry material is applied to the area, left for a few minutes to absorb the fluid, and then vacuumed or swept up. The vacuum bag or sweepings should be disposed of in a plastic bag. Broom and dustpan should be rinsed in a disinfectant. No special handling is required for vacuuming equipment.

Handwashing Procedures

Proper handwashing requires the use of soap and water and vigorous washing under a stream of running water for approximately 10 seconds. Soap suspends easily removable soil and microorganisms allowing them to be washed off. Running water is necessary to carry away dirt and debris. Rinse under running water. Use paper towels to thoroughly dry hands.

Disinfectants

An intermediate level disinfectant should be used to clean surfaces contaminated with body fluids. Such disinfectants will kill vegetative bacteria, fungi, tubercle bacillus and viruses. The disinfectant should be registered by the U.S. Environmental Protection Agency (EPA) for use as a disinfectant in medical facilities and hospitals.

Various classes of disinfectants are listed below. Sodium hypochlorite solution (bleach) is preferred for objects that may be put in the mouth.

1. Ethyl or isopropyl alcohol (70%).
2. Phenolic germicidal detergent in a 1% aqueous solution (e.g., Lysol*).
3. Sodium hypochlorite with at least 100 ppm available chlorine (1/2 cup household bleach in 1 gallon water; needs to be freshly prepared each time it is used).
4. Quaternary ammonium germicidal detergent in a 2% aqueous solution (e.g., Triquat*, Mytar* or Sage*).
5. Iodophor germicidal detergent with 500 ppm available iodine (e.g., Wescodyne*).

* Brand names are used only as examples of each type of germicidal solution and should not be considered an endorsement of a specific product.

Disinfection Of Hard Surfaces And Care Of Equipment

After removing the spilled body fluid, a disinfectant is applied. Mops should be soaked in the disinfectant after use and rinsed thoroughly or washed in a hot water cycle before reuse. Disposable cleaning equipment should be placed in a plastic bag. Nondisposable cleaning equipment (dust pans, buckets) should be thoroughly rinsed in the disinfectant. The disinfectant solution should be promptly disposed down a drain pipe. Remove gloves and discard in appropriate receptacles.

Disinfection Of Rugs

Apply sanitary absorbent agent, let dry and vacuum. If necessary, mechanically remove with dust pan and broom, then apply rug shampoo (a germicidal detergent) with a brush and revacuum. Rinse the dust pan and broom in disinfectant. If necessary, wash brush with soap and water. Dispose of nonreusable cleaning equipment as noted above. If a wet vacuum is used, run 1/2 gallon of a 1:10 dilution of chlorine bleach in water through the machine after use. It is not necessary to dismantle the machine.

Laundry Instructions For Clothing Soiled With Body Fluids

The most important factor in laundering clothing contaminated in the school setting is elimination of potentially infectious agents by soap and water. Addition of bleach will further reduce the number of potentially infectious agents. Clothing soaked with body fluids should be washed separately from other items. Presoaking may be required for heavily soiled clothing. Otherwise, wash and dry as usual. If the material is bleachable, add 1/2 cup household bleach to the wash cycle. If material is not colorfast, add 1/2 cup nonchlorine bleach (e.g., Clorox II, Borateem) to the wash cycle.

Adapted from "Prevention of Disease Transmission in Schools," Connecticut State Department of Education, 1986, and from The State of Connecticut AIDS Guidelines for State Personnel, Revised 1989.

APPENDIX H

EDUCATING STUDENTS WITH CHRONIC INFECTIOUS DISEASES A MODEL POLICY OR ADMINISTRATIVE PROCEDURE FOR LOCAL BOARDS OF EDUCATION

The _____ Board of Education adopts the following policy for educating students known to have a chronic infectious disease (e.g., AIDS/HIV infection, CMV, hepatitis B, herpes simplex) and for ensuring a safe and healthy school environment for all students.

1. All children in Connecticut have a constitutional right to a free, suitable program of educational experiences.

2. As a general rule, a child with a chronic infectious disease will be allowed, with the approval of the child's physician, to attend school in a regular classroom setting and will be considered eligible for all rights, privileges, and services provided by law and existing policy of _____school district.

3. The school nurse, with the written permission of the parent/guardian, will function as (a) the liaison with the child's physician, (b) the child's advocate in the school (i.e., assist in problem resolution, answer questions) and (c) the coordinator of services provided by other staff.

4. The school will respect the right to privacy of the individual and maintain strict confidentiality of any records containing health information. Therefore, knowledge that a child has a chronic infectious disease will be confined to those persons with a direct need to know and authorized by the parent/guardian. Those persons will be provided with appropriate information concerning the child's needs and confidentiality requirements.

5. Based upon individual circumstances, special programming may be warranted. Special education will be provided if determined to be necessary by the Planning and Placement Team.

6. Under certain circumstances a child with a chronic infectious disease might pose a risk of transmission to others. If any such circumstances exist, the school medical advisor, in consultation with the school nurse and the child's physician, must determine whether a risk of transmission exists in school. If it is determined that a risk exists, the student shall be removed from the classroom.

7. A child with a chronic infectious disease may be temporarily removed from the classroom for the reasons stated in #6 until an appropriate school program adjustment can be made, an appropriate alternative education program can be established, or the medical advisor determines that the risk has abated and the child can return to the classroom.

   (a) Removal from the classroom will not be construed as the only response to reduce risk of transmission. School personnel should be flexible in developing alternatives and should attempt to use the least restrictive means to accommodate the child's needs.

(b) In any case of temporary removal of the student from the school setting, state regulations and school policy regarding homebound instruction will apply.

8. Each removal of a child with a chronic infectious disease from normal school attendance will be reviewed by the school medical advisor in consultation with the parent/guardian and the student's physician at least once every month to determine whether the condition precipitating the removal has changed.

9. A child with a chronic infectious disease may need to be removed from the classroom for his/her own protection when other communicable diseases (e.g., measles or chicken pox) are occuring in the school population. This decision will be made by the child's physician and parent/guardian in consultation with the school nurse and/or the school medical advisor.

10. Routine and standard procedures wil be used to clean up after a child has an accident or injury at school. All staff will be trained to use such procedures. Blood or other body fluids emanating from **any** child, including ones known to have a chronic infectious disease, should be treated cautiously. Gloves should be worn when cleaning up blood spills. These spills should be disinfected with either bleach or another disinfectant and persons coming in contact with them should wash their hands afterwards. Blood-soaked items should be placed in leakproof bags for washing or appropriate disposition. Similar procedures are recommended for dealing with vomitus and fecal or urinary incontinence in **any** child. Handwashing after contact with a schoolchild is not routinely recommended unless physical contact has been made with the child's blood or body fluids, including saliva. Staff who are identified to be at substantial risk of direct contact with blood or body fluids containing blood should be offered hepatitis B vaccinations according to OSHA regulations.

1991 adaptation of "Educating Students with Chronic Infectious Diseases, A Model Policy for Local Boards of Education," Appendix D, Prevention of Disease Transmission in Schools: AIDS, State of Connecticut Department of Education and Department of Health Services, May 1986.

APPENDIX I

TRANSPORTATION

1. Legal Mandates in the State of Connecticut regarding transportation, as of March 1992.

   a. Statutes

      (1) Sec. 10-76d (e) Duty to Provide Curb-to-Curb Transportation for Special Education Students.
      (2) Sec. 10-233c Suspension from Transportation Services
      (3) Sec. 14-44 Driver Licensing
      (4) Sec. 14-100a Child Restraint Systems
      (5) Sec. 14-275 through 14-282 School Bus and Student Transportation Vehicle Requirements, Driver Training etc.
      (6) Sec. 14-212 Student Transportation Vehicle Defined

   b. Regulations

      (1) Sec. 10-76d-19 Transportation of Special Education Students
      (2) Sec. 14-275a-1 through 14-275a-20 and 14-275b-1 through 14. 275b-131 Minimum construction and equipment standards for school buses
      (3) Sec. 14-275c-1 through 14-275c-23 Operation of School Buses
      (4) Sec. 14-275c-26 through 14-275c-35 Motor Vehicles Used to Transport Special Education Students
      (5) Sec. 14-275c-36 through 14-275c-43 Minimum Requirements for Inspection, Maintenance, and Repair of School Buses and STVs
      (6) Sec. 14-44-1 to 14-44-4 Public Service Operators Licenses

   c. Proposed Regulations

      (1) 14-275b-132 through 14-275b-150 Standards for Vehicles Used for Transportation of Mobility-Impaired Students
      (2) 14-276a-1 through 14-276a-6 Driver Training Requirements
      (3) 14-275c-44 through 14-275c-53 Responsibility of Carriers for School Bus and STV Drivers

2. Resources for further information on transportation:

   a. **Improving School Transportation Safety in Connecticut: Report of the School Transportation Safety Commission** (Pursuant to Public Act 90-112), January, 1991.

b. **Study of Transportation of Medically Fragile Children**, a four volume report prepared for special education services, Michigan Department of Education, Special Transportation, Inc., 125 Roth Drive, Lansing, MI 48911 ($10 copy).

c. **National Standards for School Buses and School Bus Operation: Special Education.** 1991, National Safety Council.

d. **Supervisor's Guide for Transporting Children with Special Health Needs**. 1991. Maryland State Department of Education and Maryland State Department of Health and Mental Hygiene. Write to: Maryland Department of Health and Mental Hygiene, 201 West Preston Street, Baltimore, MD 21201.

e. **Wheelchair and Occupant Restraint on School Buses.** 1990. U.S. Department of Transportation (DOT-HS-807-570).

f. **Transportation of School Children with Disabilities**. 1991. Legislative Commission on Critical Transportation Choices, New York State Senate.

g. **The Effective Driver of Handicapped Students.** 1991. Safeway Training and Transportation, P.O. Box 177, Kingston, NH 03848. ($19.95 each)

PUPIL TRANSPORTATION SECTION
MARYLAND STATE DEPARTMENT OF EDUCATION
200 WEST BALTIMORE STREET
BALTIMORE, MARYLAND 21201

GUIDE FOR TRANSPORTATION OF CHILDREN UTILIZING RESPIRATORY THERAPY

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The transportation of pupils who must continually or periodically use oxygen equipment presents a number of complex policy and procedural concerns. In an effort to provide safe and appropriate pupil transportation as well as education and protection for personnel, the following information is provided.

I. TRANSPORTATION SERVICE REQUESTS

A. The service for handicapped pupils will be requested through the already established procedures developed for services requests. These are available through the Division of Special Education, Maryland State Department of Education, or the local education agency (LEA).

B. Service for a non-handicapped child (regular pupil with special service requirement) will be requested through the established procedures for request for special services.

II. LOCAL HEALTH DEPARTMENT ROLE

A. The local health department should be represented on the ARD Committee.

B. The local health department should assist in determining qualifications for special aides along with the local department of education.

C. The local health department should assist with the development process in cooperation with the LEA to assure that aides meet appropriate qualifications.

III. OTHER RESOURCES

A. The Coordinating Center for Home and Community Care, P.O. Box 618, Severn Professional Building, Millersville, MD 21108, may serve as a resource.

B. Oxygen equipment manufacturers may supply materials and resource personnel.

IV. SPECIAL INSTRUCTION (SCHOOL BUS AIDE, NURSE, AND DRIVER)

A. The bus aide must be provided information on:

1. The appropriate emergency number (usually 911) to be called;

2. The type of problem to be communicated to emergency personnel when contacted;

3. How to report and what to report in an oxygen-related emergency; and

4. Basic safety procedures to follow until emergency personnel arrive.

B. The nurse/aide must know manual techniques for maintaining oxygen patency in the event of oxygen equipment malfunction.

C. The nurse, aide, and driver must be provided information on transporting oxygen as addressed in Part VII.

V. SCHOOL VEHICLE

A. A sign should be conspicuously posted near each door which specifies:

CAUTION - OXYGEN IN USE
NO SMOKING, NO OPEN FLAMES

B. All oxygen cylinders must be secured to prevent movement and leakage. All requirements specified by equipment manufacturers must be met.

C. When assigning seats, consider the student's proximity to heaters and other types of motors.

D. A two-way communication system should be provided if transportation is by school bus.

VI. EMERGENCY VEHICLES

Procedures for accidents should be developed for situations when fire is not present as well as for when a fire is present or likely.

VII. GENERAL CONCERNS IN THE USE OF OXYGEN

A. Small amounts of oxygen released would not normally create a particular hazard.

B. In an oxygen-enriched atmosphere, materials that are combustible and flammable in air ignite more easily and burn more vigorously.

C. The occurrence of a fire requires the presence of combustible or flammable materials, an atmosphere of oxygen, and a source of ignition. Combustible materials may be unavoidably present when oxygen is being administered, but flammable liquids and ignition sources are avoidable.

D. Combustible materials which may be found near children receiving respiratory therapy include but are not limited to hair, clothing, facial tissues, eyeglass frames, combs, etc.

E. A particular hazard exists when pressurized oxygen equipment becomes contaminated with oil, grease, or other combustible material.

F. Oxygen-enriched atmospheres may exist in the immediate vicinity of all oxygen administration equipment.

G. Sources of ignition would include not only the usual ones in ordinary atmospheres but others which become significant hazards in oxygen-enriched atmospheres. Examples of these include open flames, burning tobacco, and electrical equipment such as heaters and other electrical motors. Additionally, certain types of sparking toys can create a potential source of ignition.

H. A hazardous condition exists if containers are located so that they may become overheated or tipped over.

I. Liquid oxygen can cause frostbite on contact with skin.

J. Oxygen containers should not be left on a bus because of heat, which can cause the expansion and possible release of oxygen.

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NATS/PT
1/19/87

SAMPLE FORMS

1. PLANNING CHECKLIST FOR IHCP AND IEP DEVELOPMENT
2. INDIVIDUALIZED HEALTH CARE PLAN AND EXAMPLE PLAN
3. PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF SPECIALIZED HEALTH CARE PROCEDURE IN SCHOOL
4. PARENT'S PERMISSION FOR THE ADMINISTRATION OF SPECIALIZED HEALTH CARE PROCEDURE IN SCHOOL
5. DOCUMENTATION OF TRAINING: HEALTH CARE PROCEDURE
6. TRANSPORTATION INFORMATION FORM
7. STUDENT EMERGENCY PROCEDURE INFORMATION AND VEHICLE STUDENT EMERGENCY INFORMATION CARD
8. NURSING CARE FLOW SHEET

SAMPLE

PLANNING CHECKLIST FOR IHCP AND IEP DEVELOPMENT
For Students with Special Health Care Needs

FAMILY
- ❑ Goals/priorities
- ❑ Liaison
- ❑ Collaboration
- ❑ Communications
- ❑ Other

HEALTH SERVICES
- ❑ Health assessment, including student strengths
- ❑ Individualized health care plan
- ❑ Emergency plans
- ❑ Health status monitoring
- ❑ Specialized health procedure
- ❑ Health teaching/counseling
- ❑ Medication
- ❑ Personnel training
- ❑ Personnel supervision
- ❑ Staff consultation
- ❑ Family support/liaison
- ❑ Physician consultation/orders
- ❑ Parent authorization(s)
- ❑ Release of information to/from health care provider
- ❑ Other

TRANSPORTATION
- ❑ Vehicle
- ❑ Access
- ❑ Safety
- ❑ Equipment
- ❑ Positioning
- ❑ Emergency plan
- ❑ Communications
- ❑ Special assistance
- ❑ Evacuation
- ❑ Aide
- ❑ Other

ACCESS
- ❑ School entrance
- ❑ Hallways
- ❑ Stairs/elevator
- ❑ Classroom/specials
- ❑ Bathroom
- ❑ Health room
- ❑ Cafeteria
- ❑ Library
- ❑ Locker
- ❑ Gym
- ❑ Playground
- ❑ Other

FIRE SAFETY
- ❑ Evacuation plan
- ❑ Evacuation practice
- ❑ Back-up plan
- ❑ Other

SCHEDULING
- ❑ Length of day
- ❑ Number of days
- ❑ Rest periods
- ❑ Flexible schedule
- ❑ Testing schedule
- ❑ Other

THERAPIES
(Assessment/Service)
- ❑ Occupational therapy
- ❑ Physical therapy
- ❑ Speech language pathology
- ❑ Other

OTHER RELATED SERVICES
- ❑ Social work
- ❑ Counseling
- ❑ Psychology
- ❑ Other

TUTORING/HOME/HOSPITAL

- ❑ Supplemental in school tutor - regular, intermittent
- ❑ Plan for continuous programming school/home/hospital
- ❑ Extra set of books at home
- ❑ Regular home/hospital program
- ❑ Other

OTHER PROGRAM ADAPTATIONS

- ❑ Curriculum/instruction
- ❑ Special equipment
- ❑ Activities of daily living
- ❑ Scheduling of health interventions
- ❑ Positioning
- ❑ Mobility
- ❑ Special diet
- ❑ Other

OTHER

EXTRACURRICULAR ACTIVITIES

- ❑ Special learning opportunities e.g. work experience
- ❑ Extended day program
- ❑ Clubs
- ❑ Sports
- ❑ Social events
- ❑ Transportation
- ❑ Access
- ❑ Other

FIELD TRIPS

- ❑ Medication plan
- ❑ Emergency plan
- ❑ Personnel
- ❑ Transportation
- ❑ Other

COMMENTS:

Adapted (in part) with permission from the Federation for Children with Special Needs: *Checklist of items for consideration in developing IEPs for students with physical disabilities or special health needs.*

SAMPLE

INDIVIDUALIZED HEALTH CARE PLAN

NAME _____ DOB _____ SEX ____ ALLERGIES _____ PHYSICIAN _____

RELEVANT DIAGNOSES _____

DIET _____ MOBILITY _____ EQUIPMENT _____

MEDICAL HISTORY _____

MEDICATION/TREATMENT _____

SIGNATURE _____ SIGNATURE _____ SIGNATURE _____

(Parent) (Student) (School Nurse)

Liaison with Family: Dates of Medical Orders: / / /

DATE	HEALTH PROBLEM/ NURSING DIAGNOSIS	STUDENT GOALS	INTERVENTION AND RESPONSIBLE PERSON	EVALUATION AND TIMELINE

Adapted from Hartford Public Schools for use in Connecticut Department of Education Guidelines for Students with Special Health Care Needs

NAME: _____

DATE	HEALTH PROBLEM/ NURSING DIAGNOSIS	STUDENT GOALS	INTERVENTION AND RESPONSIBLE PERSON	EVALUATION AND TIMELINE

Adapted from Hartford Public Schools for use in Connecticut Department of Education Guidelines for Students with Special Health Care Needs

SAMPLE INDIVIDUALIZED HEALTH CARE PLAN (INCOMPLETE)

NAME_____ DOB_____ SEX____ ALLERGIES_____PHYSICIAN(S)_____

RELEVANT DIAGNOSES_____

DIET_____MOBILITY_____EQUIPMENT_____

MEDICAL HISTORY_____

MEDICATION/TREATMENT_____

SIGNATURE_(PARENT)_____SIGNATURE_(STUDENT)_____SIGNATURE_(SCHOOL NURSE)_____

SCHOOL - FAMILY LIAISON: MEDICAL ORDERS:

Initiated Date RN	HEALTH PROBLEM/ NEEDS/NSG. DIAG.	STUDENT GOALS/OUTCOMES	INTERVENTIONS/RESPONSIBLE PERSON	Evaluated Date RN
	Potential for ineffective airway clearance as related to: _____ _____ _____	Student will have effective aeration and maintain baseline respiratory status.	The school nurse will assess student's respiratory status upon arrival to school, make a classroom assessment daily and PRN. - Monitor equipment, check for following: Trach, size/type_____placement_____ Suction machine_____ Suction catheter kits_____ Oxygen supply/mist_____ Ambu bag with mouth and trach adaptors_____Size:____ Trach care supplies_____ Student notebook for parent communication_____ Respiratory baseline:_____ _____ _____ _____ _____ _____ Follow Trach Care Procedure/Protocol _____ _____ Suction/PRN_____ Use 2cc N/S lavage The nurse will be available in school._____ _____ The school nurse will document on flow sheet data daily. The school nurse will record a monthly summary of nurses' notes as needed.	

Adapted with permission from The New Britain Memorial Hospital.
(Authors - Bonczek, R. and Papillo, J.)

NAME:_____

STANDARD OF CARE

Initiated Date RN	HEALTH PROBLEM/ NEEDS/NSG. DIAG.	STUDENT GOALS/OUTCOMES	INTERVENTIONS/RESPONSIBLE PERSON	Evaluated Date RN
	Knowledge deficit as related to: _____ _____	Teachers/Staff will understand students' healthcare needs and the student will be safely mainstreamed into the class. Student will learn to tell the teacher/ nurse early signs of airway clearance. Student will learn to avoid potentially harmful situations.	The nurse will educate teachers/administrator/staff involved in students' care for: _ Disease process - purpose of trach _ Health care needs _ Importance of airway management by nurse The nurse will collaborate daily/PRN with staff and family The nurse will have monthly/PRN contact with primary M.D. Assess child's readiness to learn, incorporate developmental needs Develop a trusting relationship Identify student's strengths_____ _____ Maximize student's strengths and allow opportunities to teach student signs and symptoms of airway impairments _____ _____ Assist student in identifying potentially harmful situations leading to impaired airway clearance _____ _____ _____ _____ _____ The student/family will update nurse as needed for any changes in healthcare status/regime_____ _____ _____	

Adapted with permission from The New Britain Memorial Hospital.
(Authors - Bonczek, R. and Papillo, J.)

NAME: _____

STANDARD OF CARE

Initiated Date RN	HEALTH PROBLEM/ NEEDS/NSG. DIAG.	STUDENT GOALS/OUTCOMES	INTERVENTIONS/RESPONSIBLE PERSON	Evaluated Date RN
	Emergency potential for decannulation of tracheostomy tube.	Student will not experience decannulation during the school day. Minimize sequelae in an event of emergency.	The nurse will anticipate potential problems and develop an emergency plan EMERGENCY PLAN: _____ Equipment: _____	

Adapted with permission from The New Britain Memorial Hospital.
(Authors - Bonczek, R. and Papillo, J.)

SAMPLE

PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF SPECIALIZED HEALTH CARE PROCEDURE IN SCHOOL

1. Student: _____ Birth date: _____
2. Address: _____
3. Medical condition for which the procedure is to be performed:
   _____
4. Name of procedure:
   _____
   _____
5. Check one if applicable:
   - ☐ I reviewed and approved the attached procedure as written.
   - ☐ I reviewed and approved the attached procedure with modifications.
   - ☐ I have attached my specific written procedure and recommendations.
6. Precautions, possible untoward reactions, and interventions: _____
   _____
   _____
7. Time schedule and/or indication for the procedure: _____
   _____
   _____
8. The procedure is to be continued as above until (date): _____

Physician's signature: _____ Date: _____

Address: _____ Telephone: _____

_____

Date: _____

TO WHOM IT MAY CONCERN:

I hereby give my permission for exchange of confidential information contained in the record of my child.

Name: _____ Birth date: _____

between _____ and _____.

_____
Signature of parent/guardian

Adapted from Eastconn Regional Education Service Center for use in Connecticut Department of Education Guidelines for Students with Special Health Care Needs

SAMPLE

PARENT'S PERMISSION FOR THE ADMINISTRATION OF SPECIALIZED HEALTH CARE PROCEDURE IN SCHOOL

We (I), the undersigned, who are the parents/guardians of:

Name:_____ Birth date:_____

request that the following specialized health care procedure be administered to our child:

_____

We understand that a qualified designated person(s) will be performing the above mentioned health care procedure.

It is our understanding that the designated person(s) will use the procedure written into the student's health care plan according to nursing standards and physician orders.

Name: _____

Address: _____

Telephone No.: _____

We will notify the school immediately if the health status of _____ changes, we change physicians, or the procedure is changed or cancelled.

We understand that, whenever possible, the specialized health care procedure should be provided before or after school hours.

Signature of parent(s)/guardian(s): _____

Address: _____

_____

Telephone (home): _____ (work): _____

Date: _____

Adapted from Eastconn Regional Education Service Center for use in Connecticut Department of Education Guidelines for Students with Special Health Care Needs

SAMPLE

DOCUMENTATION OF TRAINING: HEALTH CARE PROCEDURE

Specific Procedure: _____

Student's Name: _____

Participants:

Trainer: _____
Signature/Title

Trainee: _____
Signature/Position

Dates:

_____	Review of information and outline
_____	Demonstration of technique
_____	Return demonstration
_____	Supervised procedure
_____	Supervised procedure
_____	
_____	
_____	Competency in procedure demonstrated
_____	Begin intermittent supervision (ongoing) and document on student log.

Notes:

Adapted from Eastconn Regional Education Service Center for use in Connecticut Department of Education Guidelines for Students with Special Health Care Needs

SAMPLE

TRANSPORTATION INFORMATION FORM

BUS INFORMATION

_____ A.M.
_____ P.M.

(Student's Name)	Bus No.
Address	Home Phone
Parent/Guardian Name	Work Phone (Dad)
Babysitter's Name	Work Phone (Mom)
Sitter's Address	Teacher's Name
School	Sitter's Phone

PARENT NOTE: My child can walk to and from the bus independently. Yes ☐ No ☐

* Please star address above to denote drop-off point

_____
Parent Signature

1. Method of Communication:

2. Method of Mobility: _____

3. Possible Emergencies:	Y	N	LOOK FOR	INSTRUCTIONS
Seizure				
Fainting				
Severe Insect Allergy				
Breathing Problems				
4. Behavior Modification Plan				
5. Other:				

Safety Equipment:

	YES	NO	SPECIAL INSTRUCTIONS
1. Seat belt			
2. Car seat			
Regular			
Special			
3. Booster			
4. Harness			
5. Other			

Equipment: ☐ Stays on bus

☐ Doesn't stay on bus

- Obtain from (circle one):

  parent busyard school other: _____

- Return to (circle one):

  parent busyard school other: _____

Additional Comments:

_____

_____

_____

_____

_____

SAMPLE

EASTCONN

Regional Educational Service Center

HEALTH PROGRAM PROCEDURES

III. Student Emergency Procedure Information

A. Emergency Procedure Information shall be maintained on all students and will include: home address, phone number, parent/guardian place of employment and phone number, name and phone number of student's physician(s), and name and phone number of at least two other contact people who can be called in an emergency to assume responsibility for the student if the parent is unavailable.

This information shall accompany the student on all trips from the school

B. Teaching staff shall be made aware of any student with medical conditions which may require immediate attention, i.e., allergy, seizure disorder.

C. A student Emergency Information Card shall be carried on the EASTCONN vehicle regularly transporting each student (see next page). Parents will be requested to complete the following information: student's name, address, parent/guardian home phone number, two (2) emergency contact phone numbers (parent employment, other) student's physician, chronic medical conditions, medication taken on regular basis.

* Vehicle Emergency Cards shall be maintained in a **sealed** labeled envelope readily displayed within each vehicle.

* EASTCONN's Director of Transportation shall be responsible for maintaining vehicle emergency cards for all students transported by EASTCONN vehicles.

Adapted from Eastconn Regional Education Service Center for use in Connecticut Department of Education Guidelines for Students with Special Health Care Needs

SAMPLE

VEHICLE STUDENT EMERGENCY INFORMATION CARD

Name: _____
Last First M.I.

Address _____
City State Zip Code

Date of Birth _____ Age _____ Sex: Male _____ Female _____

Telephone # _____

Destination School

1. PARENT/GUARDIAN
   Mother _____ Father _____
   Home telephone # _____ Home telephone # _____
   Work telephone # _____ Work telephone # _____

2. BABYSITTER (a.m./p.m.)
   Name _____
   Address _____
   Telephone # _____

3. NEIGHBOR/RELATIVE
   Name _____
   Address _____
   Telephone # _____

4. PHYSICIAN
   Name _____
   Address _____
   Telephone # _____

5. EMERGENCY CONTACT
   Name _____
   Address _____
   Telephone # _____

Relevant Medical Conditions:

Current Medications and Possible Side Effects

_____

_____

Physical Limitations:

_____

_____

Visual/Hearing Limitations:

_____

_____

Communication:

_____

_____

Special Instructions:

Lifting: _____
Bus Drill Restrictions: _____
Loading/Unloading: _____
Seat Restraints: _____ Respiratory Aides: _____
Leg Braces: _____ Arm Braces: _____
Car Seat: _____ Wheelchair: _____
Emergency Procedures: _____

Additional Comments/Recommendations

_____

_____

_____

_____

_____

_____
Date Signature/Title

Adapted from Eastconn Regional Education Service Center for use in Connecticut Department of Education Guidelines for Students with Special Health Care Needs

SAMPLE

NURSING CARE FLOW SHEET

STUDENT'S NAME: _____

CLASS: _____ WEEK OF: _____

		BASELINE DATA	MON	TUE	WED	THU	FRI
ASSESSMENTS PERFORMED		Skin					
		Sensory Perceptual					
		Neurologic					
		Respiratory					
		Cardiovascular					
		Gastrointestinal					
		Genitourinary					
		Musculoskeletal					
		Developmental					
		Psycho/Social					
VITAL SIGNS		BP/Pulse/Temp/Resp					
SAFETY		Safety Measures					
TREATMENTS		Blood sugar					
		Catheterization					
		Suctioning					
ACTIVITY		Communication - Notebook/Phone					
MEETINGS		PPT/IHCP					
		Family Meeting					
HEALTH CARE EDUCATION		Student:					
		Family:					
		Other:					

NURSE INITIAL/SIGNATURE: _____/_____ _____/_____

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DATE/TIME	PROBLEM	NOTES

APPENDIX K

LEGAL ISSUES OF EDUCATING CHILDREN WITH MEDICAL NEEDS

INTRODUCTION AND SUMMARY

Advances in medical technology have increasingly made it possible for children, who are dependent on medical technology or who have chronic medical conditions, to participate in regular and special education outside of hospital or home settings. Public schools are also beginning to face the impact of the increasing number of children suffering from AIDS and from the effects of drug and alcohol addiction. In many respects such disabled children are not those originally expected to be served by public schools when the Education for the Handicapped Act (EHA), now the Individuals with Disabilities Education Act (IDEA), was enacted. The responsibility of the public schools under IDEA or the Rehabilitation Act (Section 504) to provide appropriate education and necessary related services, permitting such students' integration into public school settings, is a matter of continuing legal controversy.

Students with chronic medical conditions include children with a broad range of educational needs, from those whose cognitive abilities require no modification of the regular school academic curriculum, but who may need school health or other related services in order to participate in regular school programs, to those who need extensive special education programming. Currently, because of the continuing uncertainty as to the scope of applicable legal requirements, there may be little consistency in the way in which such students are served by local school districts or of standards applied by states in monitoring the provision of services under IDEA or Section 504. See, Walker, "Care of Chronically Ill Children in Schools," *Pediatric Clinics of North America* (Feb. 1984). There are major differences in the way that courts and due process hearing officers address the scope of related services. Further, courts have yet to address the scope of liability faced by school personnel charged with serving medically fragile students.

This legal analysis addresses current legal rulings regarding eligibility for services under IDEA and Section 504, the scope of required related services, considerations of less restrictive setting, and school district liability, as they impact on the education of students with medical needs.

ELIGIBILITY FOR SERVICES

IDEA requires state and local school districts to provide a free appropriate public education to "all children residing in the State who have disabilities," ... who are in need of special education and related services. {20 U.S.C. s. 1412.} "Children with disabilities" have "mental retardation, hearing impairments including deafness, speech or language impairments, visual impairments including blindness, serious emotional disturbance, orthopedic impairments, autism, traumatic brain injury, or other health impairments, or specific learning disabilities, who by reason thereof require special

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"Legal Issues of Educating Children with Medical Needs," by Kristen Reasoner Apgar, Esq., Director, Bureau of Special Education Appeals, Massachusetts Department of Education. Adapted with permission of the author.

education and related services {20 U.S.C. s.1404(a) (1)}, and whose disabilities "adversely affect (their) educational performance." {34 C.F.R. s. 300.5(b)(1)-(11)}. Thus, there must be a nexus between the child's disability and a special education need in order to be eligible for services under IDEA.

In most instances the children with medical needs who do not have other disabilities will be covered by the definition of "other health impaired" in IDEA regulations. ("Other health impaired" includes those children who have limited strength, vitality or alertness due to chronic or acute health problems, such as health condition, tuberculosis, rheumatic fever, nephritis, asthma, sickle cell anemia, hemophilia, epilepsy, lead poisoning, leukemia, or diabetes, which adversely affects a child's education performance {34 C.F.R. s. 300.5(b)}.

In instances where the cognitive functioning of a child with medical needs is affected by their disability, there would not appear to be any question that the student is covered by IDEA - since he or she would likely come within one or more of the disability categories and would need special education, as well as related services. However, where the child's cognitive potential is severely limited, as in the case of the child involved in the *Timothy W. v. Rochester New Hampshire School District* (875) F.2d 954 (1st Cir. 1989), the child's capacity to benefit from access to public education may be questioned and public schools may resist serving the student, especially where the student's educational program may consist almost exclusively of related services. *Timothy W.* suggests, however, that the threshold for meeting the need for special education is very low or nonexistent. In that case, the court cited the inclusion of physical education as a special education service under IDEA when it involves motor skill patterning, adaptive PE, or physical or motor fitness. The court described the special education component and, therefore, the child was in need of special education under IDEA. Similar views are expressed in *Polk v. Central Susquehanna Intermediate Unit*, 853 F.2d 171, 176 (3rd Cir. 1988), where the court found that a special education program could consist almost exclusively of physical therapy.

SERVICES UNDER SECTION 504

Medically involved students who do not have cognitive deficits requiring special education, but whose medical condition may require related services, such as supervision of routine medication or testing (e.g., blood sugar tests for a diabetic condition) by a nurse, specialized transportation, occupation or physical therapy, have consistently been excluded from the protections and procedures of IDEA. See, for example, *Doe v. Belleview Public School District,* 674 F. Supp. 1524 (M.D. Fla 1987) (Student with AIDS not covered by IDEA, because he had no need for special education). Nevertheless, such students are "qualified handicapped individuals" within the provisions of Section 504.

Unlike IDEA, the Section 504 Regulations applicable to public school systems (in particular, 34 C.F.R. s. 104.31, .39) include the provision of related aids and services to handicapped children who need such services in order to participate in regular education. Students are eligible for the protections of Section 504 if they have a physical or mental impairment, which limits one or more major life activity, a record of impairment, or are regarded as having an impairment. When children attend public school or are of school age, they are entitled to appropriate regular or special education and related services. Public schools are obligated to evaluate students to see if they are in need of special education or related services, handicapped students may not be discriminated against in the provision of programs and services offered by the public

school, and they are entitled to be served as adequately in regular education as are non-handicapped students. If there is a dispute over the provision of education, the public school must also provide for a due process hearing. 34 C.F.R. 104.3. See, *Rothschild v. Grottenthaler,* 725 F. Supp. 776 (S.D.N.Y. 1989) aff'd in part, 907 F. 2d 286 (2d Cir. 1990) (Section 504 guarantees meaningful access to benefits that the public school confers, ordering provision of sign language interpreter to deaf parents for school conferences involving their child).

The overall scope of the services that must be made available to handicapped regular education students with chronic medical conditions, while addressed in various Office for Civil Rights' rulings, has yet to be clearly developed in court decisions. See, for example, Yorktown Central School District, 16 EHLR 108 (OCR 1989) (Student with asthma entitled to special transportation.)

RELATED SERVICES UNDER IDEA

Decisions under IDEA exclude noneducational services from school district responsibility, but there is great difficulty in defining "noneducational." In *Irving Independent School District v. Tatro*, 468 U.S. 883 (1984), the U.S. Supreme Court addressed the availability of catheterization as a related service, holding that it was included under the then EHA as a school service, because it was necessary to permit the student to access special education and could be provided by a school nurse or a specially trained layperson, rather than a physician. Similarly, see, *Department of Education of the State of Hawaii v. Katherine D.* 727 F.2d 809 (9th Cir. 1983).

Nondiagnostic services provided by physicians, including psychiatrists, and hospital services have generally been found to be outside the scope of services required by IDEA. See, *Darlene L. v. Illinois State Board of Education*, 568 F. Supp. 1524 (N.D.Ill.1983), which held that psychiatric services and hospitalization were medical services excluded from coverage under the Act.

Similarly, the recent case of *Clovis v. California Office of Administrative Hearings*, 903 F.2d 635 (9th Cir. 1990), determined that placement of a student at an acute care facility for treatment of emotional and psychiatric needs was a medical placement and the school district was not required by IDEA to pay for hospital services. The court stated that the standard to be followed in determining whether the placement is an educational one for which the school district is responsible under IDEA is whether the placement is necessary for educational purposes or is in response to medical, social, or emotional problems that would make it necessary apart from the learning process. Clovis explicitly rejected the argument that if a student's educational, social emotional, and medical needs are intertwined, the state or local school district may be required to fund a psychiatric placement. (Compare, *Vander Malle v. Ambach,* 667 F. Supp. 1015 (S.D.N.Y. 1987), which required the state to pay for services at a psychiatric hospital because of the interrelated nature of the student's emotional and educational needs.)

There are also conflicting lines of cases involving school districts' obligation to provide nursing and transportation services to technology-dependent students. *Detsel v. Board of Education of Auburn*, 637 F. Supp. 1022 (N.D.N.Y.1986), aff'd 820 F.2d 587 (2d Cir. 1987), cert. denied, 108 S. Ct. 495 (1987), and *Bevin v. Wright,* 666 F. Supp.71 (W.D.Pa. 1987), hold that there must be reasonable limitations on the scope of nursing care as a related service under IDEA, and that such a limitation cannot be based simply

on whether the service provider must be a physician. Where a child's medical condition is such that he or she needs constant monitoring, e.g., checking vital signs, suctioning, administering medication or being ready to administer cardio-pulminary resuscitation, in order to attend school, the provision of such services falls outside the range of school health services contemplated by the *Tatro* decision, even though the services may be performed by a nurse.

Thomas v. Cincinnati Board of Education, 1988-89 EHLR DEC. 441:517 (S.D. Ohio 1989), reversed, 918 F.2d 618 (6th Cir. 1990), and *Macomb County Intermediate School District v. Joshua S.*, 715 F. Supp. 824 (E.D. Mich. 1989), held the opposite view. They stated that under *Tatro* school districts must provide any specialized service, including monitored transportation, which can be performed by a nurse, if those related services are needed to permit a child to attend an appropriate public school program. *Thomas and Macomb* argued that the *Detsel* and *Bevins'* "reasonableness" standard had no basis in IDEA and were contrary to *Tatro*.

Like the students in Detsel and Bevins, the students in *Macomb and Thomas* had multiple medical needs necessitating extensive nursing services. In *Macomb*, the issue was whether the school district was obliged to transport the student to a public-school-based special education program, if in order to safely transport the student, it would have to provide the services of an individual able to correctly position the student in the vehicle, to suction the student who used a tracheostomy tube, and to deal with any emergencies arising from the student's medical condition. The court held that *Tatro* required the school district to provide the transportation services because they were necessary in order to permit the student to have meaningful access to special education.

Similarly, in *Thomas*, the school district argued that the extensive medical needs of the student, who was severely cognitively impaired, as well as medically involved, made transportation to school too dangerous, especially when weighted against the uncertainty that she could make any educational progress, and offered only limited homebound instruction. After analyzing the student's medical status, the district court determined that she could be transported to school, ordering the school district to provide the necessary personnel to provide for her feeding and suctioning while enroute to school. The court added that even though the student was thought to be the most severely cognitively impaired child in the school system, and her ability to progress was unknowable, she was still entitled to the protections of IDEA. However, in November 1990, the 6th Circuit of Appeals reversed the District Court's decision and reinstated the homebound instruction originally offered by the Cincinnati School District. The Court of Appeals disputed the lower court's findings that it was necessary for the student to be educated in a public school-based special education class in order to receive educational benefit, as required by IDEA. Rather, the Appeals Court concluded that to the extent that the student could benefit from special education, it was possible to receive educational benefit from services provided in a home setting, and thus the offer of such an IEP satisfied the requirements of the IDEA.

LEAST RESTRICTIVE ENVIRONMENT

As indicated from the above cases, the **setting** in which medically-involved students are entitled to receive education is likely to be the subject of legal controversy. Where the student's medical needs are serious, the school district may argue that homebound instruction is medically necessary. The district courts in *Thomas and Macomb* relied heavily on the least restrictive environment requirement of IDEA and followed the

reasoning in *Roncker v. Walter* 700 F.2d 1058 (6th Cir. 1983). A school system must demonstrate that the child's appropriate program cannot feasibly be provided in a less restrictive setting before placing a child in an institutional or home setting. Although the courts looked to testimony of medical experts to assess the feasibility of transporting the students, the *Thomas and Macomb* district court decisions largely discounted school districts' concerns about cost or safety in favor of choosing the least restrictive setting. In contrast, the Appeals Court decision in Thomas discounted the pertinence of the least restrictive environment (LRE) requirement to a severely disabled student like *Emily Thomas*. The court remarked that since it was undisputed that the student was "unable to benefit from the social contact that a school setting provides . . . the mainstreaming concept is simply inapplicable" (Thomas, 918 F.2d., at 52). Further, unlike the district court, the 6th Circuit was persuaded that professionals involved with the student had legitimate concerns about the safety of transporting her to and from the public school in an ambulance. Significantly, the 6th Circuit did not even address the applicability of Roncker to its analysis of the LRE obligations of the public school system.

Detsel also ignored the possibility that absent provision of school-based nursing services, the student in that case would be confined to home, even though she could be educated in mainstream classes. [Although not evident from the decision itself, the Auburn Public Schools apparently agreed to fund the in-school nursing services during the course of the Detsel's litigation against it and HHS (see below)].

Other federal court decisions have taken a more restrictive view of the LRE requirements of IDEA than Roncker. In Drew P. v. Clarke County School District, 676 F. Supp. 1559 (M.D. Ga. 1987) and Daniel R.R. v. State Board of Education, 874 F. 2d 1036 (5th Cir. 1989), the courts limited the financial obligation of school systems to create new programs in a student's neighborhood school and considered evidence of the student's capacity to participate in and benefit from the curriculum being offered to the typical students, as part of the circumstances under which a school must agree to extensive modifications necessary to permit a child to be educated in the mainstream. Under this more limited view of the LRE requirement of IDEA, students with significant cognitive deficits like those in *Macomb* and *Thomas* are likely to be found unable to benefit from education in the public school setting and the school districts will not be required to provide the transportation services or nursing services needed to enable such students to attend public school setting and the school districts will not be required to provide the transportation services or nursing services needed to enable such students to attend public school programs.

ACCESSING THIRD PARTY RESOURCES TO PROVIDE FOR SCHOOL-BASED NURSING SERVICES

Following their unsuccessful effort to have the courts order the Auburn School District to pay for nursing services, the *Detsels*, with the cooperation of Auburn, sought to have Medicaid cover the cost of their daughter's school-based nursing services, just as it covered nursing services she required when at home. In *Detsel v. Sullivan*, 895 F.2d 58 (2d Cir. 1990), the Court of Appeals held that the U.S. Department of Health and Human Services was required to fund school-based private duty nursing services, because such services were medically necessary and provided in the least restrictive setting, which for a school-age child is at school.

Thus, *Detsel v. Sullivan* suggests an alternative to expanding of the scope of related services covered by IDEA, namely access to medical benefits delivered in the public school at third party expense. To the extent that the reluctance of school districts to provide extensive nursing services is primarily the result of cost, the decision provides an alternative means for assuring that students with extensive medical needs can be served in public school settings. However, the right to access third party payments for services, which are covered under medical insurance but may also be considered related services under IDEA, may often be limited to those instances where Medicaid, rather than private medical insurance, is involved. (See, *Chester County Intermediate Unit v. Pennsylvania Blue Shield*, 16 EHLR 925 (3rd Cir. Feb. 1990) (Private insurers not required to pay for medical benefits which are required under IDEA).

SCHOOL DISTRICT LIABILITY

School officials may raise understandable concerns regarding their legal liability, when school districts are obliged to serve students with potentially life-threatening medical conditions. To date there have been few judicial decisions addressing school district liability for injuries to special education students, and none have addressed the situation of students with medical disabilities. Court decisions have generally not held school districts to a higher standard of care for disabled students than that applicable to typical students. See: *Brooks v. St. Tammany Parish School Board,* 510 So.2dd 51 (La. App. 1 Cir. 1987) (School district was not liable for injuries sustained by a disabled student, who was injured in the school playground, since child's mainstream education, required by IDEA, included integration with typical students in the school playground); also *Jane Doe A. v. Special School District of St. Louis County, 16 EHLR 1000 (8th Cir. April 17, 1990)* (School district and school officials were not liable under Section 1983 of the Civil Rights Act for sexual assaults committed by a school bus driver on disabled students, where there was no pattern of unconstitutional acts on the part of school officials, or of deliberate indifference in training of school personnel or review of prior complaints lodged against the bus driver); and *Rabena v. City of New York* 556 N.Y.S. 2d 807 (N.Y. Civ CT. 1990) (Doctrine of **res ipsa loquitur** was not applicable to injury to severely disabled child, who apparently was injured while being transported home from school, where there was no specific evidence of negligence on the part of school authorities or the transportation provider).

But compare *Beretto v. Sparta Community Unit District*, 544 N.E. 2d 1140 (Ill. App. 5 Dist. 1989) (A school district could be liable for injuries to a student in a wheelchair, arising from the defective condition of the wheelchair) and *Guidry on behalf of Meche v. Rapides Parish School Board*, 560 So.2d 125 (La.App.1990) (School district was liable for sexual assault on a retarded student by another student, where the staff failed to properly supervise students and reasonably could be expected to know that students might engage in inappropriate sexual behavior.)

Such decisions are largely based on state tort liability laws. In some states, school districts continue to be immune from suit under sovereign immunity. In others, there may be applicable "Good Samaritan" laws which would limit the scope of employee liability for rendering emergency treatment. In addition, state laws may vary with regard to the type of medically-related services that school nurses or trained lay persons may legally provide. In the case of a student who receives nursing or other medically-related services while in school, compliance with state licensure and training standards would almost certainly be a factor in deciding if the school district met its obligation of exercising "due care" in the provision of services to medically fragile student, who is injured or suffers a medical emergency while at school.

A number of states have enacted guidelines for the education and/or transportation of medically fragile students. In those states, e.g., Florida, California, Washington, Connecticut, and Michigan, the standard of care legally expected of school districts would likely include compliance with applicable state education and safety procedures, as well as generally accepted practice in the field. See, Stephens, Beekman, Munk, Stefans, *Study of Transportation of Medically Fragile Children*, Michigan Department of Education (1989); Medically Fragile Technical Assistance Manual, Washington Superintendent of Public Instruction (1989). Also, Haynie, Porter, Palfrey, *Children Assisted by Medical Technology in Educational Settings: Guidelines for Care*, Boston Children's Hospital, 1989. These publications address the importance of appropriate training for public school-based and pupil transportation staff, utilization of the school nurse and child's pediatrician or other health care provider as the coordinator for the child's in-school services, and development of emergency procedures, to be communicated to all who will be in contact with the student.

"Legal Issues of Educating Children with Medical Needs," by Kristen Reasoner Apgar, Esq., Director, Bureau of Special Education Appeals, Massachusetts Department of Education. Adapted with permission of the author.

Connecticut State Department of Education
Division of Education Support Services
Middletown

TO: Non-Public School Administrators
Directors of Special Education Facilities

FROM: Tom B. Gillung, Acting Division Director

DATE: December 2, 1991

SUBJECT: Delegation of Nursing Responsibilities Based on Rulings and Recommendations of the Connecticut Board of Examiners for Nursing

The Board of Examiners for Nursing has completed its review of 53 nursing care activities that may be required by students with special health care needs.

NURSING ACTIVITIES THAT CANNOT BE DELEGATED

As a result of their review, the Board has ruled that some of these activities are licensed nursing functions that cannot be delegated under any circumstances to unlicensed persons. These nursing functions and activities are listed on attachment A: "NURSING FUNCTIONS AND ACTIVITIES THAT CANNOT BE DELEGATED TO UNLICENSED SCHOOL PERSONNEL IN THE STATE OF CONNECTICUT."

The Board of Examiners for Nursing also states that the following aspects of the nursing process are licensed nursing functions that cannot be delegated:

1. The initial nursing assessment and any subsequent assessment or intervention that requires nursing knowledge, judgment and skill.

2. The derivation of the nursing diagnoses, establishment of the nursing care goals, and development of the nursing care plan including assurance of patient/client participation in the planning process.

3. Any nursing intervention which requires nursing knowledge, judgment and skill.

4. The evaluation of the patient/client's progress, or lack of progress, toward goal achievement. This evaluation determines the revision of the nursing care plan and requires professional nursing judgment.

NURSING ACTIVITIES THAT CAN BE DELEGATED

Other nursing activities in the school can sometimes be delegated by the professional school nurse to unlicensed personnel. The decision that it is safe to delegate such activities in a specific situation is made by the school nurse after a thorough nursing (health) assessment. To whom the activity will be delegated should be determined collaboratively with the school administrator and other appropriate school personnel. Furthermore, the delegation of a specific nursing activity to other school personnel may be limited by collective bargaining laws and by the job descriptions of those employees.

Each student must be assessed individually by the school nurse before the decision can be made that it is safe to delegate a nursing activity. For example, unlicensed persons can usually assist special needs students with putting on or removing an article of clothing. However, in the rare instance that a student is at high risk for bone fracture with movement and handling, the school nurse would not delegate to an unlicensed person the task of assisting this student with clothing. In another situation, the school nurse may determine that it is safe to delegate the monitoring of a drip method gastrostomy feeding. After the nurse determines that it is safe to delegate this function, the school administrator and school nurse, together with other appropriate persons such as the classroom teacher, should determine together who might best be assigned the task of monitoring the feeding. The designated employee should be willing to take on the responsibility and it should be within the scope of his or her job description.

The nursing activities listed on attachment B, "NURSING ACTIVITIES THAT CAN SOMETIMES BE DELEGATED TO UNLICENSED PERSONNEL IN THE STATE OF CONNECTICUT" can be delegated if the school nurse has first:

1. assessed the student's health status and needs;

2. determined that delegation is appropriate;

3. provided training to the unlicensed person;

4. determined that the trained person is competent to provide safe care; and

5. developed a plan of on-going supervision.

When the school nurse delegates care, either to a licensed practical nurse (LPN) or an unlicensed person, the school nurse remains responsible for the quality and outcome of care. Therefore, the school nurse is responsible to:

1. provide supervision of the person to whom the nurse delegates care;

2. evaluate the outcome of care; and

3. revise the student's health care plan and/or the delegation decision accordingly.

Some of these nursing activities are also within the scope of practice of other health professionals such as the physical therapist, occupational therapist and speech-language pathologist. Decisions by other health professionals to delegate such care should be done in collaboration with the school nurse and based on the total health status of the student.

Any questions on specific issues related to delegation of nursing responsibilities should be directed either to Elaine Brainerd (638-4227) or Nadine Schwab (638-4244) at the State Department of Education or Marie Hilliard, at the Board of Examiners for Nursing (566-1041).

TBG:sk
Enclosures

ATTACHMENT A

NURSING FUNCTIONS AND ACTIVITIES THAT CANNOT BE DELEGATED TO UNLICENSED SCHOOL PERSONNEL IN THE STATE OF CONNECTICUT:

- health assessment;
- health care planning and evaluation;
- medication administration, except as provided by statute, including subcutaneous, intramuscular, intravenous or rectal medications, except that injectable medication for a student with a medically diagnosed allergic condition can be delegated to a teacher or principle (C.G.S. regulations Section 10-212a-2(f);
- administration of intravenous fluids;
- intravenous hyperalimentation/lipids administration;
- insulin Pump - problem assessment/intervention;
- gastrostomy feeding (bolus method or including medication);
- initiation of gastrostomy feeding (drip method (monitoring of the drip feeding can be delegated) after initiation by the licensed nurse;
- nasogastric tube feedings;
- oxygen administration (PRN/intermittent) or initiation of continuous oxygen;
- nebulizer with oxygen or medication;
- oropharyngeal suctioning;
- tracheostomy suctioning;
- tracheostomy care;
- respirator/ventilator care;
- respiratory therapy (percussion and postural drainage are limited to registered nurses, licensed practical nurses and physical therapists);
- urinary catheterization, including clean intermittent catheterization (CIC);
- reinsertion of an indwelling urinary catheter;
- ostomy care (care of stoma and changing the appliance);
- temporary insertion of a foley catheter gastrostomy tube;
- cast care;
- warm applications (limited to nurses, physical therapists and occupational therapists);
- sterile dressings;

(Attachment A continued)

- o decubitus ulcer care (prevention activities can be delegated but not specific wound/ulcer care);
- o blood specimen collection/testing (including finger stick);
- o blood glucose monitoring;
- o intake and output measurements of gastric and parenteral fluids; and
- o charting (unlicensed persons can contribute but documentation regarding assessment, planning and evaluation of care are licensed functions).

ATTACHMENT B

NURSING ACTIVITIES THAT CAN SOMETIMES BE DELEGATED TO UNLICENSED PERSONNEL IN THE STATE OF CONNECTICUT:

- o vital signs;
- o height & weight;
- o oral hygiene or nail, hair and skin care;
- o clean dressings;
- o ostomy management (emptying and monitoring the integrity of the bag);
- o cool applications;
- o preparing nourishment;
- o feeding student (orally);
- o monitoring of a drip method gastrostomy feeding that has been initiated by the nurse;
- o intake and output measurement and documentation (except gastric and parenteral fluids);
- o assist student to take own medication;
- o oral, topical and inhalant medications by teacher or principal according to C.G.S. Sec. 10-212a;
- o emergency administration of medication by injection for a student with a known allergy according to C.G.S. Section 10-212a or Section 52-557b;
- o monitoring shunt function;
- o nebulizer treatment (routine non-medicated and non-oxygenated mist only);
- o spirometer;
- o monitoring of continuous oxygen;
- o oral suctioning (mouth only - not pharynx);
- o care of an incontinent student;
- o assistance with bedpan and urinal;
- o non-medication aspects of bowel and bladder training.
- o external catheter care;
- o external care of indwelling catheter;
- o transfers;
- o aspects of a prescribed exercise and/or range of motion program;
- o assistance with clothing;
- o braces and prostheses - donning, doffing and weaning into;
- o assisted ambulation (crutches, walker, cane); and
- o positioning.

APPENDIX M

RESOURCES

There are a wealth of local, state and federal resources regarding health, education, children with special health care needs and technology-dependent children that school personnel and families can access for information, technical assistance and/or support. Lists of such resources already exist and can readily be accessed through services and agencies in (or near) Connecticut. One such agency is the Special Education Resource Center (SERC) in Middletown. The purpose of SERC is to assist professionals and parents as they endeavor to provide an appropriate education for children and youth with special needs. It provides an array of services, information and resources related to individuals with disabilities. SERC services and resources include:

- Information/publication dissemination on programs and services in Connecticut.
- Library services, including an extensive collection of books, journals, tests, vertical file pamphlets, research abstracts and indexes, references, and in-service materials on special education.
- In-service programs, seminars and conferences at SERC or, upon request, at various locations throughout the state, within a school district or for parents' groups.
- Child Find, a service to assist in the identification of children in need of services.
- The SERC Newsletter. This publication is published several times a year and contains announcements about SERC conferences and workshops. All members receive the newsletter.

Membership in SERC is free and open to anyone interested in special education. It is also a prerequisite for borrowing materials. SERC's address and telephone number are as follows:

Special Education Resource Center
25 Industrial Park Road
Middletown, Connecticut 06457
(203) 632-1485

The following list includes other services and agencies that may be helpful as a starting point in accessing resources, depending on the specific need.

The Family Center
Department of Social Work
Newington Children's Hospital
181 East Cedar Street
Newington, Connecticut 06111
Molly Cole (203) 667-5288

Parent-to-Parent of Connecticut
Department of Social Work
Newington Children's Hospital
181 East Cedar Street
Newington, Connecticut 06111
Laura Glomb (203) 667-5288

New England SERVE
101 Tremont Street
Suite 812
Boston, MA 02108
(617) 574-9493

Commission on Children
450 Broad Street
Hartford, CT 06106-1401
(203) 566-1338

Commission on Alcohol and Drug Abuse
999 Asylum Avenue
Hartford, CT 06105
(203) 566-2773

State Department of Children and Youth Services
170 Sigourney Street
Hartford, CT 06105
(203) 566-3661

State Department of Education
25 Industrial Park Road
Middletown, Connecticut 06457

Due Process (Special Education and Section 504)
Thomas Badway (203) 638-4276
Theresa DeFrancis (203) 638-4275
Susan Kennedy, Parent Complaint Officer (203) 638-4274

Health Services Technical Assistance
Elaine Brainerd (203) 638-4227
Nadine Schwab (203) 638-4244

State Department of Health Services
150 Washington Street
Hartford, CT 06106
(203) 566-4800

Children with Special Health Care Needs
Carol Fineout (203) 566-2057

School and Adolescent Health
Marta Barker (203) 566-2057

Department of Human Resources
1049 Asylum Avenue
Hartford, CT 06105
1-800-228-5437

Department of Labor
Occupational Safety and Health
200 Folly Brook Blvd.
Wethersfield, CT 06109-1114
(203) 566-2339

State Department of Protection and Advocacy for Persons with Disabilities
608 Weston Street
Hartford, CT 06120
(203) 297-4300
1-800-842-7303

University of Connecticut Health Center
Pediatrics
263 Farmington Avenue
Farmington, CT 06032
(203) 679-2221

Connecticut State Department of Education

Division of Education Support Services
Tom B. Gillung, Acting Director

Bureau of Special Education and Pupil Personnel Services
Frank Limauro, Acting Chief

Student Support Services
Nadine Schwab, Project Manager
Elaine Brainerd

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